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Nonallergic Asthma

Differential Diagnosis and Treatment

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• *A classification of asthma into allergic and nonallergic has gained support from the more recent studies on the underlying causes of the disease.*

The majority of instances of nonallergic asthma occur after middle life and result from recurrent infections of the upper and lower respiratory tract. Status asthmaticus is a frequent complication of infectious asthma.

Chronic and intractable asthma may be present also in a patient with allergic asthma complicated by a superimposed infection of the sinuses, bronchi and lungs.

There are many secondary or precipitating causes that may bring on asthmatic paroxysms. The most important of these are acute respiratory infections, mechanical and chemical irritants, autonomic imbalance, hormonal deficiencies and psychogenic influences. These secondary causes play a more important role in nonallergic asthma because of the greater tendency to chronicity in this form of the disease.

The effective treatment of chronic asthma depends largely on the successful control of the secondary or precipitating causes of the asthmatic attacks.

The introduction of the antibiotics and corticosteroids in the treatment of infectious asthma has supplied potent weapons to combat the disease. The use of these therapeutic agents makes possible the control of two of the important pathologic lesions of asthma—bronchial infection and bronchial inflammation.

At present combined antibiotic and cortisone or hydrocortisone therapy of asthma seems to be the most rational method of preventing the disease from becoming chronic and intractable. Their value in infectious asthma is due to their anti-infective and antiflammatory action.

When prolonged treatment is essential, combined therapy also lessens the dangers arising from the presence of masked infections.

In 1860, Henry Hyde Salter, an English clinician, published a classic monograph, "Asthma: Its Pathology and Treatment."[14] This monograph was the first to present the fundamental pathologic and clinical observations on asthma. Salter, himself a sufferer from chronic asthma, had an excellent opportunity to study the clinical history of the disease and in particular the reflex phenomena which he believed played an important role in the attacks.

It is of historical interest that although written in the preallergic era, Salter's monograph mentions

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TABLE 1.—*Salter's classification of asthma*

ASTHMA	IDIOPATHIC, uncomplicated, or SPASMODIC asthma	1. EXCITING cause manifest.	INTRINSIC asthma i.e., irritant applied to the lungs themselves. — I. Asthma from fog, smoke, fumes of various kinds. II. Ipecacuan asthma. III. HAY ASTHMA. IV. ASTHMA from animal emanations. V. Asthma from certain airs. VI. Toxhaemic asthma.
			EXCITOMOTORY, or reflex asthma. — I. Peptic asthma. II. Asthma from organic nervous irritation. III. Asthma from peripheral cerebrospinal irritation.
			CENTRAL asthma . . . . . EPILEPTIC, EMOTIONAL, etc.
		2. No apparent exciting cause of attacks . . . . . PERIODIC ASTHMA	
	SYMPTOMATIC, complicated or ORGANIC asthma	Organic cause VASCULAR.	I. Asthma complicating bronchitis, common humid asthma—senile asthma. II. Cardiac asthma.
		Organic cause NERVOUS . . . . . Heberden's case, etc.	

instances of "hay asthma," "asthma from animal emanations," and asthmatic attacks brought on by the inhalation of ipecac powder. The latter occurred among pharmacists and medical students who inhaled the drug while dispensing prescriptions.

Salter was probably the first to use the term *intrinsic* in the classification of the causes of asthma. Since then this term has gained wide usage and the extrinsic-intrinsic grouping of asthmatic patients is now deeply rooted in the nomenclature. The designation of asthma as intrinsic has led to much confusion because it has been given different interpretations by different clinical observers. The term *intrinsic* as employed by Salter had reference to patients whose symptoms were the result of irritation of the lungs by the common inhalants and other irritants. According to Rackemann,[13] Alexander,[1] and other proponents of the extrinsic-intrinsic classification, the designation *extrinsic* covers those asthmatic patients whose symptoms are due to sensitization to inhalants, foods and drugs; whereas *intrinsic* has reference to persons with asthma that is not due to sensitivity and to those whose symptoms arise from many unrelated causes.

Swineford,[15] among others, has presented cogent reasons for discontinuing the extrinsic-intrinsic classification of the causes of asthma. A classification of patients into allergic and nonallergic would be less confusing and more in keeping with present-day knowledge of the underlying causes of the disease.

The concept of nonallergic asthma as a syndrome in which wheezing is the diagnostic feature is not supported by the pathologic findings. Chronic asthma is a disease characterized clinically by wheezing respiration and dyspnea, physiologically by bronchospasm and pathologically by edema and hypersecretion of the bronchial mucous membrane. In some instances thickening of the walls of the bronchi is also present.

The extensive research which followed the von Pirquet era, a half century ago, laid the groundwork for the present knowledge of allergic phenomena and made possible a better understanding of the causes of allergic asthma. The great emphasis focused on the study of allergic asthma has, however, diverted attention from the large group of patients whose asthma comes on after middle life and in whom chronicity is a common clinical feature.

Success or failure in the management of the patients with chronic asthma of the nonallergic type depends largely on our ability to control the secondary or precipitating causes of the attacks. Before discussing the present-day procedures employed in the direct therapeutic attack on the primary causes of asthma, it is important to consider the significance of the secondary or precipitating causes.

Climate. Many exciting or precipitating causes of asthmatic paroxysms are recorded in the literature. Climatic influences (temperature, relative humidity, barometric pressure) have been stressed by students of the disease[12] since Salter's original observations. There is little doubt that asthma of the nonallergenic or infectious type usually occurring past middle life is benefited by a warm, dry climate. However, in the case of a patient with allergic asthma and superimposed infection, particularly in the case of pollen-sensitive patients, the physician must first be assured that the region is

TABLE 2.—Causes of asthma

PRIMARY	SECONDARY (Precipitating)	PRIMARY
I. Infection (bacterial, virus) (nonimmunologic) II. Allergy plus infection (combined immunologic and nonimmunologic)	1. Acute respiratory infections 2. Climate (temperature, relative humidity, barometric pressure) 3. Physical agents (light, heat, cold) 4. Chemical irritants 5. Mechanical irritants 6. Glandular dysfunction (thyroxine, estrogen, androgen, adrenocortical steroids) 7. Autonomic imbalance 8. Psychogenic	III. Allergy (immunologic)
CONDITIONS FREQUENTLY PRESENT IN INFECTIOUS ASTHMA		**CONDITIONS FREQUENTLY PRESENT IN ALLERGIC ASTHMA**
1. Suppurative sinus disease 2. Chronic bronchitis 3. Emphysema (true) 4. Bronchiectasis 5. Obstructive bronchitis 6. Bronchial stenosis 7. Chronic lung disease		1. Hyperplastic sinus disease (polyposis) 2. Allergic cough 3. Allergic bronchitis 4. Emphysema (functional) 5. Urticaria 5. Eczema 7. Gastrointestinal allergy

free of the inhalants to which the patient is sensitive. The physician who advises a change of climate assumes considerable responsibility and the patient who at great mental or financial hazard seeks relief through a change of climate and is not benefited thereby, may return with the psychic setback which results from failure. Better and more lasting improvement is usually obtained by environmental control, with attention to heating of the home, proper ventilation and the removal of irritating substances from the patient's home surroundings.

Autonomic, Hormonal and Psychogenic Factors. These influences play a secondary, although significant, role in initiating and prolonging attacks of nonallergic asthma. It has already been stressed that the same factors are also excitants in allergic asthmatic patients but because of the pronounced tendency to chronicity in nonallergic asthma they assume considerably more importance. The autonomic nervous system is the great regulating and coordinating mechanism of the body. As is well known, reflex stimulation of the vagus and sympathetic nerves plays a very important part in the contraction and relaxation of the smooth muscle of the bronchi. Relief of an asthmatic paroxysm by relaxation of the smooth muscle of the bronchi through epinephrine stimulation of the sympathetic terminals is one of the most effective therapeutic measures. Little is as yet known, however, of the action of other endocrine secretions — thyroxin, estrogen, androgen, pituitary and adrenal steroids— on the sympathetic-parasympathetic mechanism in its relation to asthma. Further studies on the role of the pituitary and adrenal cortex in relation to the ketosteroid excretion may throw additional light on the asthma problem.

The revival of interest in psychosomatic medicine in recent years has placed more emphasis on the psychogenic factor in asthma. One need not stress the importance of psychodynamic influences on body function. These influences are well recognized in many chronic diseases such as those affecting the gastrointestinal, circulatory, urinary and respiratory systems. Although there is no evidence that psychic factors alone without allergy or infection can cause asthma, they may be among the most potent factors in precipitating a paroxysm or modifying the disease to the extent that the asthmatic state becomes chronic and intractable. The beneficial therapeutic effects that an adjustment to life situations has on an asthmatic patient, and the relief obtained after the correction of anxiety states, are so often observed that they cannot be overlooked. A rational viewpoint is to regard the role of the psyche in asthma somewhat between the view of those who maintain that asthma is psychogenic and the view of the skeptic who is of the opinion that psychic influences are of little or no importance.

DIFFERENTIAL DIAGNOSIS

A clinical diagnosis of asthma is easily made in the presence of wheezing respiration, particularly if wheezing is accompanied by dyspnea. Determination of the cause of the asthma, however, requires a more intensive search, and a thorough history is of the greatest value. History alone will frequently

TABLE 3.—*Differential diagnosis of nonallergic and allergic asthma*

HISTORY	
NONALLERGIC	ALLERGIC
1. No family history of allergy. Attacks of asthma not related to inherited predisposition.	1. Positive family history of allergy. Attacks of asthma related to inherited predisposition.
2. History of other allergic manifestations unusual.	2. History of other allergic manifestations usually elicited.
3. Occurrence of asthma more common after middle life.	3. Asthma usually occurs before middle life.
4. Attacks usually ushered in by cold or bronchitis at a time of year when bronchial infections are common.	4. Attacks come out of clear sky. Occur at a time when persons with whom patient has contact are unaffected.
5. Attacks of asthma usually single.	5. Attacks usually recurrent.
6. Each attack usually clears up without residual symptoms.	6. Mild symptoms often persist between attacks.
7. No relation of asthma to inhaled substances or foods.	7. Inhaled substances or foods are frequently found to be causes of asthma.
8. No itching of mucous membranes.	8. Itching of conjunctival, nasal and pharyngeal membranes.
9. Status asthmaticus.	9. Constitutional reactions.

TABLE 4.—*Differential diagnosis of nonallergic and allergic asthma*

EXAMINATION	
NONALLERGIC	ALLERGIC
1. Visible mucous membranes hyperemic, red.	1. Visible mucous membranes pale, glistening, edematous.
2. Mucopurulent nasal discharge and sputum.	2. Thin watery mucoid nasal discharge, mucoid sputum.
3. Smear of nasal or bronchial secretion usually shows predominance of polymorphonuclear leukocytes.	3. Smear of nasal or bronchial secretion shows predominance of eosinophils.
4. Sinus involvement, if present, is of purulent type.	4. Sinus involvement, if present, is of hyperplastic type (nasal polyps).
5. Roentgenograms of lungs usually show peribronchial thickening and in chronic asthma x-ray evidence of emphysema.	5. Roentgenograms of lungs usually show slight or no bronchial markings.
6. Skin tests usually negative.	6. Skin tests usually positive.
7. No urticaria, eczema or other allergic manifestations.	7. Urticaria, eczema, or other allergic manifestations often present.

lead to a correct diagnosis of the underlying cause or causes. When the information obtained from the history and physical examination of the patient with suspected nonallergic asthma is inadequate for diagnosis, more extensive examinations are necessary. These may include clinical laboratory studies of the sputum for bacterial flora, tests to determine whether eosinophilia is present, and routine sensitivity tests on the skin to rule out possible allergic asthma with superimposed secondary infection of the sinuses and bronchi.

A routine rhinological examination should be done to determine the appearance of the nasal and pharyngeal membranes. Pallor and swelling of the nasal and pharyngeal membranes and a translucent uvula are characteristic of uncomplicated allergic asthma. However, this classic appearance may be masked by secondary infection. In the case of asthma due to both allergy and infection, a rhinologic examination will disclose the existence of suppurative or hyperplastic sinus disease. The recurrent polyposis in the latter condition may lead to narrowing of the bronchi through the nasal-pulmonary reflex, a mechanism which needs further study.[4]

Roentgenograms of the lungs in infectious asthma usually show peribronchial thickening and, in persons with chronic asthma, evidence of emphysema. Visualization of the bronchial tree, which can be done with a little more discomfort to the patient and only slightly more expense, will yield vastly more information. Bronchograms may show the presence of bronchiectasis and narrowing of the bronchi and mediastinal and peribronchial masses from other causes—foreign bodies, polyps and kinks from contracting scars.

Because of the chronicity of nonallergic asthma, the question of a cardiac component must be considered. Although chronic asthma and heart disease may occur together, so-called cardiac asthma usually occurs in patients with a known history of heart disease which has imposed a load on the left ventricle. If the bronchi respond to the pulmonary congestion by spasm or if the lumina of the bronchi are narrowed by edema of the bronchial mucosa, asthmatic wheezing rales may be present. In that event, asthma of long standing may be associated with chronic emphysema and enlargement of the right side of the heart, resulting in cor pulmonale. One should, therefore, rule out the cardiac factor by clinical observation, physical examination, electrocardiogram and x-ray studies.

TABLE 5.—*Diagnostic procedure in nonallergic asthma*

1. History
2. Physical examination
3. Skin tests
4. Rhinoscopic
5. Roentgenograms of lungs
6. Bronchogram
7. Bronchoscopy
8. Electrocardiogram
9. Laboratory
   Sputum—Routine culture
   Sensitivity tests for antibiotics
   Nasal smear
   Blood count (eosinophilia)
10. Pulmonary function
    Timed vital capacity
    Maximum breathing capacity

TREATMENT

There are few chronic illnesses which present such a therapeutic challenge to the physician as does chronic asthma. Effective treatment, particularly of patients in status asthmaticus has been greatly aided by the advances in knowledge of antibiotics and adrenocortical steroids. These, however, should not lessen the interest in general and preventive measures. Patients with chronic asthma of the infectious type require careful supervision. Proper nutrition is essential and except in instances of allergic asthma complicated by secondary respiratory tract infection in which sensitization to foods is unmistakably present, rigid restrictions in diet may be harmful to an already debilitated patient. Vitamin supplements and the correction of any existing anemia are important. Instructions to patients with chronic asthma should include instruction as to dietary habits and environmental control, the early treatment of acute respiratory infections, and avoidance of fatigue, emotional stress and undue physical effort.

Drugs play an important role in the treatment of asthma. The value of epinephrine, ephedrine, aminophyllin and antihistamines is too well known to require more than mention. It is unfortunate that their introduction in the treatment of asthma has lessened interest in the iodides. The iodides are particularly helpful in the treatment of chronic infectious asthma where the tenacious sputum is an important problem. Iodides may lessen the tendency to exhausting cough, so prevalent in infectious asthma, by keeping the sputum more fluid. In Hyde Salter's day, the iodides were hailed as the most important drugs in the treatment of chronic asthma and Salter devoted many pages of his monograph to stress their value.

Antibiotics. The introduction of antibiotic therapy in the control of respiratory tract infections and of infectious asthma has made possible a fundamental attack on the causative bacteria. Prolonged or long-term treatment with antibiotics is more effective not only in preventing early relapses, but also in controlling chronic infectious asthma. In these instances, choosing the appropriate antibiotic and the method of administration is very important.[6]

Cultures and sensitivity tests should be made promptly. Material for sensitivity tests may be obtained from the infected sinuses, which are among the commonest causes of acute infectious asthma, or from a specimen of deep sputum. Where bronchoscopy is indicated, as in the event of complicating bronchiectasis, mucous plugs removed in the process may be cultured and tested. Until the results of sensitivity tests are known, the selection of an antibiotic is of necessity empirical. In these circumstances a broad spectrum antibiotic may be used.

Of utmost importance is the immediate and effective control of acute upper and lower respiratory tract infections in the early stages. If the results of sensitivity tests are not available, the oral administration of broad spectrum antibiotics which attack both Gram-positive and Gram-negative organisms will frequently give better results. Oral antibiotic therapy should be continued for at least five or ten days until the secretions from the sinuses and the sputum have become less purulent. This will prevent the transition from an acute to a chronic respiratory infection resulting in infectious asthma. Inadequate dosage may give temporary relief but will not spare the patient the discomfort of asthma lasting weeks or months. Early, adequate antibiotic therapy, therefore, becomes one of the most valuable measures in preventing an acute infection of the sinuses, bronchi or lungs from bringing on recurrent asthmatic paroxysms.

In the control of chronic infectious asthma, prolonged antibiotic therapy may be carried out over a period of months or several years. When so used, the antibiotic must be carefully selected. Sensitivity tests must be the guide, even though not infallible, because of the changing bacterial flora which may follow antibiotic therapy.

In status asthmaticus, where time is of the essence, an injectable antibiotic should be used. Penicillin is the one most widely given despite the well known anaphylactic reactions. This hazard may be lessened by combining penicillin in the same syringe with an injectable antihistaminic drug.

Aerosols have been highly recommended as an effective method for long-term treatment of chronic infectious asthma. This method of antibiotic therapy has some advantages. It is comparatively safe, free from side reactions, except for oral and pharyngeal irritation, and permits of self-administration by

simple and economical techniques. It is questionable, however, whether the blood levels of the antibiotics obtained by aerosolization are sufficient to be of value except in the less severe forms of infectious asthma.

Steroid Hormones. The profound effect produced by the corticosteroids on metabolism and especially on the balance of the electrolytes has been the subject of intensive research ever since their importance in therapy became known. The role of these hormones in infections is thus far little understood. It has been suggested that they lessen the inflammatory reaction and thereby the tendency to localization of the infection. Their anti-infective action may be due not to their inhibition of bacterial growth, but rather to the protection which they give the cells of the host against the liberated bacterial toxins.[9] Regardless of the lack of a satisfactory explanation of the mode of action, the value of the steroid hormones in infectious asthma is now well established.[3, 8] When properly used they are one of the most important additions to the therapy of status asthmaticus.

Where prolonged treatment with cortisone or hydrocortisone is used, the well known safeguards against untoward reactions must always be carried out. The proper selection of patients and the maintenance of dosage at the lowest level necessary to keep the patient symptom-free are essential for the safe employment of these hormones. Atrophy of the adrenal cortex may follow long-term therapy with these steroids. This can be in part overcome by the simultaneous injection of ACTH gel during the period of prolonged oral or intramuscular use of the hormones.

When the asthmatic attacks become resistant to all the well known methods of treatment and result in status asthmaticus, hydrocortisone or corticotropin may be given by slow intravenous infusion. This method of therapy has the advantage of bringing the hormones in quick contact with the tissues and cells of the host. Intravenous infusion in critically ill patients with status asthmaticus should be accompanied by intramuscular injections of cortisone or hydrocortisone until the emergency has been met. The presence of other infections is no contraindication to the unrestricted use of these steroids in chronic intractable asthma, particularly when combined with antibiotics. The latter will lessen the hazard of other masked infections which may be present. Combined treatment with adrenocortical hormones and antibiotics has been shown to be more effective than therapy with either steroids or antibacterial drugs alone.[7]

Physiotherapy. The importance of physical methods of improving respiration was stressed by

TABLE 6.—*Treatment of nonallergic asthma*

1. GENERAL AND PREVENTIVE MANAGEMENT
   - Rest
   - Diet
   - Nutrition
   - Correction of anemia and hormonal dysfunction (thyroid, estrogen, androgen)
   - Removal of focal infection (teeth, paranasal sinuses)
   - Early effective treatment of acute respiratory tract infections
2. ENVIRONMENTAL CONTROL AND DESENSITIZATION IN COMBINED FORMS (allergy plus infection)
3. DRUGS
   - Iodides
   - Adrenalin
   - Ephedrine
   - Aminophyllin
   - Antihistamines
4. ANTIBIOTICS
5. ADRENOCORTICAL STEROIDS AND CORTICOTROPIN
6. COMBINED ANTIBIOTIC AND ADRENOCORTICAL STEROID THERAPY
7. PHYSIOTHERAPY (breathing exercises)
8. PSYCHOTHERAPY

the Asthma Research Council of London more than 20 years ago.[10] It is well known that in normal breathing the respiratory muscles alter the configuration of the thorax so that on inspiration air inflates the lungs. This air is expelled by the elastic recoil of the lungs with each expiration. During an asthmatic paroxysm, inspiration becomes easier than expiration. The accessory muscles of respiration are able to overcome the obstruction caused by the generalized spasm of the smooth muscle of the bronchioles and the edema of the mucous membranes of the bronchi. Because of this obstruction in the bronchi, frequently aggravated by the development of mucous plugs, the lungs become overdistended. The degree of emphysema which develops and its reversibility or irreversibility depends largely on the chronicity of the asthmatic condition. In the less severe and less chronic forms of asthma, an asthmatic paroxysm causes only temporary overdistention of the lungs, which return to normal after the attack.

The resulting emphysema is not associated with irreversible changes in the thorax and lungs and may be designated as functional emphysema. If such attacks are of long duration and occur over a period of years, the chest adapts itself to the overdistended lungs and assumes a barrel shape with widening of the costal angles and a secondary enlargement of the lungs. True emphysema of this type is not an unusual finding in chronic asthma.

The primary object of breathing exercises in asthma is to restore the lungs and chest cavity to normal size. Such exercises will often improve the excursion of the lower ribs and diaphragm and restore the lungs and thorax to a comparatively

normal state. Exercises designed to encourage diaphragmatic breathing are useful in functional emphysema associated with the less intractable forms of chronic infectious asthma. Abbreviated abdominal breathing has been suggested also as a prophylactic measure in bringing a beginning asthmatic paroxysm under control.[2, 5] Thus far, the method of evaluating improvement in pulmonary ventilation which may result from breathing exercises has been limited to hemithorax measurements. A more exact method of measuring the degree of bronchial obstruction as it affects the ventilation capacity in a chronic asthmatic patient both at rest and following exercise will no doubt be developed. The intensive studies on pulmonary function[16] now being carried out in many hospital laboratories in the United States should yield very valuable information on the effectiveness of physical exercises in chronic asthma.

Psychotherapy. The psychotherapeutic management of a patient with chronic intractable asthma differs only in minor details from that employed in the psychotherapy of any chronic disease. In an asthmatic child, whether the condition be due to allergic causes or is an aftermath of infectious disease—bronchitis, pneumonia, whooping cough or measles—the emotional pattern may be shaped to a great extent by family environment. In recent years greater emphasis has been placed upon maternal influences. This, however, is not true of patients past middle life in whom chronic intractable asthma develops as a result of infection. In this older group of patients, the pattern of behavior usually has been well established before the onset of the distressing symptoms which characterize recurrent asthmatic paroxysms. An anxious, depressed, dependent and phobic person will naturally have a more violent emotional response to such attacks than one who, when in good health, has shown emotional stability and normal adjustments to life situations.

Every understanding physician uses psychotherapy in the care of patients. Much of what he may do is inherent in the doctor-patient relationship. To be successful in the management of the emotional problems of patients with chronic asthma, the physician must take the time to advise, suggest and reassure.

In the majority of instances the physician who treats the organic causes underlying a patient's asthmatic condition is in the best position to minister to the patient's psychotherapeutic needs. However, where the situation demands the more specialized techniques, he should refer the patient to a cooperative psychiatrist. The psychiatrist is qualified by training to know the significance of the psychologic stresses which may give rise to such emotional responses as anxiety, fear, resentment, hostility, frustration, rivalry and guilt. The fruitful results achieved by the cooperation of a rhinologist when the asthma problem is complicated by sinus disease should encourage similar cooperation on the part of the psychiatrist when the correction of a fundamental psychogenic component is essential for a successful result.

Centuries ago Socrates[11] with his profound insight must have had in mind the psychosomatic approach to the treatment of disease when he admonished: "Let no one persuade you to cure him until he has given you his soul to be cured, for this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."

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Neurosurgery in General Practice

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• The advances in the field of neurological surgery permit satisfactory treatment of problems heretofore looked upon as nonremediable. Visible abnormalities of the head should be analyzed carefully for neurological implications and possibilities of correction. The relief of pain by specific pain pathway interruption can be both gratifying and merciful, and if it is to be carried out, should not be withheld until the terminal stages of disease. Common symptoms such as epilepsy and subarachnoid hemorrhage deserve full scale investigation with an eye to elucidation of the causative factors and proper therapy.

RAPID MEDICAL PROGRESS often outstrips the cognizance of physicians busy in the urgent affairs of practice and an occasional review of certain aspects of specialized fields of interest can be of value. Surgery of the nervous system and of its bony coverings has advanced in both diagnosis and treatment to such an extent that some diseases previously considered unamenable to surgical correction may now be successfully controlled or rendered less severe if attended early. Present concepts in the surgical management of certain common as well as rare problems will be considered here.

CONGENITAL AND DEVELOPMENTAL DEFECTS

Hydrocephalus. Abnormal growth of an infant's head is readily visible and measurable in a semiquantitative way and will attract the attention of the parents as well as of the physician. Two of the common mechanisms causing this growth are pathologic collections of fluid in the extra-arachnoid subdural spaces and obstruction to the free passage of cerebrospinal fluid.

All babies with abnormally increasing head size should be studied in a hospital where the subdural space can be examined as one of the first procedures in elucidating the mechanism of the increase. Subdural collections of fluid with a high protein content may be the result of bleeding into this space, although the causes of the bleeding are not always understood and the importance of trauma is not as evident as in the cases of adult patients with similar collections. Collections also may follow purulent meningitides, and again the pathogenesis would need elucidation, but the treatment is clear. It is to be remembered, however, that the increase in head size may only be slight, and that it is not an inevitable accompaniment of these diseases. Abnormal subdural fluid collection requires prompt treatment in the form of repeated evacuation and complete excision of the offending fluid-filled envelope. Failure to administer prompt treatment leads to irreparable brain damage in a critical phase of brain growth. These processes are progressive and potentially lethal.

"Internal" hydrocephalus results from an obstructive process in the pathway of cerebrospinal fluid passage. Although the cerebrospinal fluid is probably not exclusively formed in the ventricles of the brain but throughout the neuraxis, nevertheless, blockage of passage of the fluid within the ventricles as well as in the extraventricular channels will lead to a dilatation of the ventricular system (initially at the expense of the white matter) and will produce, if unrelieved, a severe thinning of the cerebral mantle and eventual death. The hitherto uniformly pessimistic outlook in such cases is not altogether justified, for surgical amelioration is possible in some cases of hydrocephalus that develop after birth. Certainly all such cases deserve study. Infantile hydrocephalus is often associated with some degree of spinal dysraphism, lumbosacral meningomyelocele being the most common form. The cause of hydrocephalus in such infants can frequently be explained by a developmental defect of the hindbrain—the Arnold-Chiari malformation. The hydrocephalus that sometimes develops after the successful repair of a mild form of dysraphism may occasionally be relieved by a decompression of this hindbrain deformity. Infantile hydrocephalus that is not associated with spinal or cranial dysraphism is caused by internal blockage of the ventricular system. Such blockage, commonly in the aqueduct of Sylvius, is usually caused by defects in the formation of the aqueduct, although examples of neoplasia do occur uncommonly. Babies with this obstructive internal hydrocephalus may be considered for successful by-passing or shunt procedures whereby the blockage of the aqueduct is overcome by the construction of an artificial channel.

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Infantile hydrocephalus is also caused by poorly understood defects in fluid exchange, both formation and absorption. The cerebrospinal fluid may "circulate" freely within and outside the ventricles, but an excess rapidly accumulates, and if not continuously removed it causes serious degrees of head growth and brain destruction. In about 60 per cent of the cases of hydrocephalus with internal obstruction as well as those in which free flow of fluid can be demonstrated in all passageways, surgical measures may successfully transport the cerebrospinal fluid into ureter, peritoneum or other serous-lined absorbing cavities. Newer methods of returning this fluid to the vascular system are undergoing trial.

The parents ought not be encouraged to hope too much unless careful study of the infant establishes, first, that the type of hydrocephalus is amenable to surgical attempts and, second, that the baby has some reasonable prospect of normal maturation. A surgical exercise which prolongs a recognizably and hopelessly defective life is ill-advised. The process of ventricular enlargement can progress at great speed, destroying in a matter of weeks the only chance of salvage. Therefore, early evaluation is mandatory if this condition is suspected.

Cranial Synostosis. Like hydrocephalus this deformity is visible in the developing contour of the infant's cranium. The cranial sutures fuse prior to the completion of normal brain growth, and the pattern of deformity is determined by the location of the suture or sutures which are prematurely closed. Varying combinations of suture closure may give bizarre shapes to the baby's head. Associated congenital stigmata may accompany the defect in cranial bone relationships, including syndactylism, cleft palate and facial bone deformity. If the progressive cranial deformity is remedied in time, the prognosis for brain development is usually good. This condition, improperly confused with microcephaly, can be treated surgically with gratifying results. Artificial sutures are constructed to replace those prematurely closed, thus permitting once again normal expansion of the bones of the skull as brain growth continues.

It will become increasingly clear why early correction of this defect is mandatory when it is recalled that 60 per cent of brain growth is completed within the first year of life. Any arresting process such as cranial suture closure within this first year will have disproportionate effect on brain development as compared with other body organs whose initial rate of growth is not so striking. Surgical correction can help bring about a more normal contour of the skull, and, although cosmetic considerations are not primary in this disease, treatment will aid appearance as well as provide space for proper brain growth. Operative correction should be undertaken at the time the diagnosis is made, which should be in the first months of life (see Figures 1 and 2).

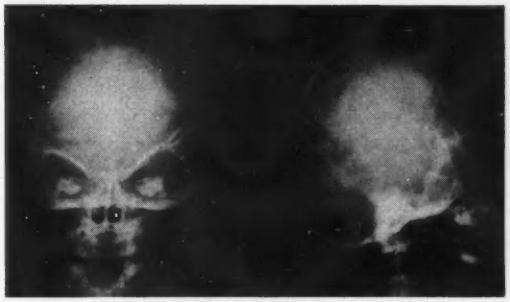

Figure 1.—Preoperative roentgenograms of a 5-year-old boy with advanced skull deformity and mental defect associated with premature closure of the coronal suture.

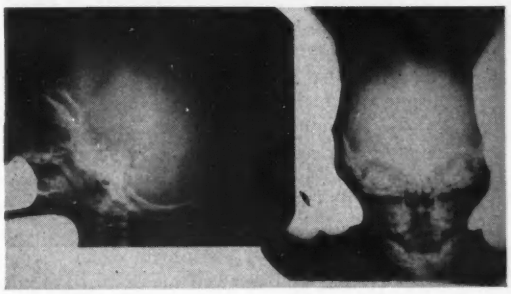

Figure 2.—Preoperative roentgenograms of a 10-month-old boy with early skull deformity and slight developmental retardation associated with premature closure of the saggital suture.

SCALP AND CRANIAL MASSES

It is a temptation to remove innocent appearing tumors of the scalp and underlying tissues without elaborate neurosurgical investigation. It is well, however, to recognize certain conditions which may be associated with major intracranial complications. This is particularly true of lesions which appear in the lines of closure of sutures and infolding of the developing central nervous system. Midline lesions, for example, are always suspect. Too often the small "wen" lying in the mid-saggital plane of the scalp turns out to be a dermoid cyst and at times is connected with the intracranial space by a stalk or sinus. Local excision may be followed by a discharging tract, suppuration and intracranial complications of severe nature. The mass may be fluctuant and, if it contains blood, it may be a pericranial sinus. If it contains cerebrospinal fluid or brain tissue, it may be a cranial meningocele or encephalocele. Careful consideration of the nature of these masses will permit adequate planning for corrective operative treatment. Masses which are eccentrically placed also deserve close scrutiny.

Roentgenographic study of the skull including tangential views can reveal bone involvement and should be recommended in all cases. Evidence of a bony lesion in association with a visible mass at once removes the lesion from the "office procedure" group and, as in the case of midline masses, such tumors must be investigated fully and looked upon as potentially necessitating a major procedure. These more complicated lesions may require specialized neurodiagnostic studies.

INTRACTABLE PAIN

The relief of pain should and can be one of a physician's greatest services. For patients in whom local treatment of the offending lesion is no longer effective, surgical measures constitute a major bulwark against pain. An example in point is malignant disease in which the primary tumor or metastatic lesions, or both, cause pain that is not alleviated by mild analgesic drugs. The location of the painful lesion dictates the procedure to be recommended. Pain due to malignant disease which is limited to one side of the face, head or neck can uniformly be relieved by combined sensory root sections of cranial and cervical nerves in a single major operative procedure without resulting motor or psychic paralysis. Pain that is located anywhere below the nipple line, whether unilateral or bilateral in the cases of malignancy, is best treated by anterolateral thoracic cordotomy, which is an operation of precision. The success of this procedure depends not only upon close attention to technical operative details but also upon the careful selection of patients. A life expectancy in excess of four to six months is desirable for the patient to convalesce and realize the full benefits of the procedure. There must be no pain above the nipple line and the patient must not be addicted to narcotics.

It should be noted that this procedure can produce sphincter and motor weakness; such complications are usually transient and occur in a minority of patients. Paralysis is not the uniform sequel of this procedure and it should be recommended before the ravages of disease can cause severe debility and addiction. In patients suffering from abdominal and pelvic malignant disease, cordotomy is gratifyingly successful in relieving pain permanently in 80 per cent of cases.

Pain between the neck and nipple line, including pain in the upper extremity, can, if unilateral, be relieved by high cervical cordotomy. Fortunately severe bilateral pain located above the nipple line is rare and probably is best treated by lobotomy.

A word of caution should be considered with respect to lobotomy. For a severely debilitated or addicted patient with intractable pain or for a patient with bilateral pain above the nipple line, this procedure can be merciful. The price of unawareness of pain, which is the result of lobotomy, however, is personality alteration or at times annihilation. The family may no longer recognize the patient as a close relative but see him only as a stranger whose social consciousness is blunted. Intelligent patients and members of the family may prefer suffering to the possibility of personality destruction. It is, therefore, desirable to recommend the more precise and specific pain relieving procedures wherever possible before the disease becomes far advanced, and before the need for lobotomy arises (see Figure 3).

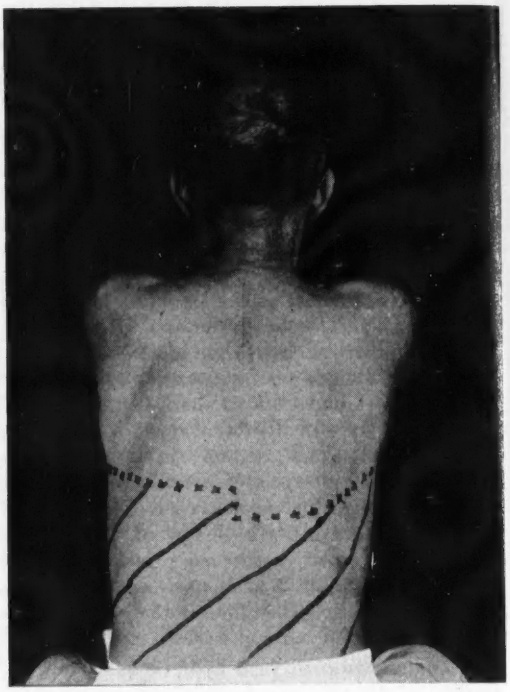

Figure 3.—Photograph showing the operative scar at the site of thoracic cordotomy and the level of total analgesia several inches below.

THE OCCURRENCE OF SPECIFIC SYMPTOMS

What common symptoms of disease are frequently treated as diseases themselves without regard for the underlying causative factors?

Epilepsy. Convulsive seizure or epilepsy is one such symptom. Little by little the wastebasket of idiopathic, essential or cryptogenic epilepsy is being emptied as we understand more of the etiologic factors behind abnormal electrical discharge within the brain. Epileptic discharge, which may masquerade as a blackout, a faint or a period of amnesia, or

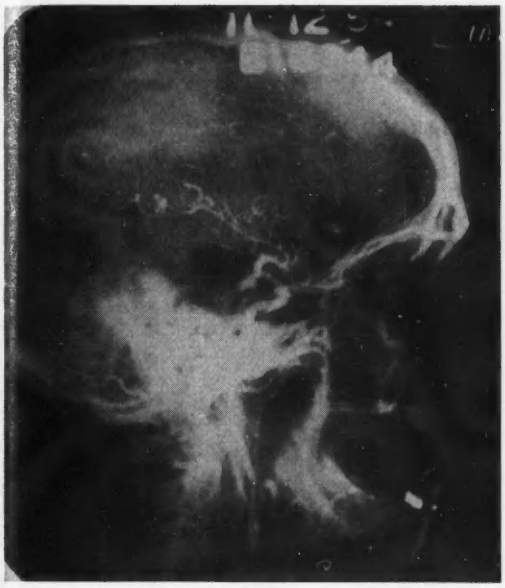

Figure 4.—Lateral angiogram demonstrating the prominent saccular aneurysm arising from the left internal carotid artery.

take the form of a specialized sensory or motor seizure, deserves careful study. Such study may require detailed observation and examination to determine the nature of the spell.

Every patient with seizures deserves assessment with an eye to uncovering focal brain disease. The location and nature of the brain disease will determine its amenability to surgical attack. Methods that can be employed include repeated electroencephalographic tracings, the use of plain radiological and gas contrast studies of the brain and cerebrospinal fluid channels, positive contrast studies of cerebral angiography, radioactive tracer uptake studies, and of course repeated neurological examinations. If the epileptic attack is due to a potentially lethal lesion such as neoplasm or abscess, it is quite understandable that the surgical effort must be directed toward this primary disease, and the treatment of the epilepsy itself becomes a secondary consideration. When the cause of the attacks is a nonprogressive process, the treatment of the convulsive disorder is the primary goal. Incapacitating seizures which are not satisfactorily controlled by medical therapy and which are due to a single accessible focus can be treated successfully by surgical means. Each case must be considered individually, for many are unsuitable for operative treatment. A hemiplegic cerebral spastic child with convulsions may be gratifyingly relieved of seizures and his rehabilitation accelerated by excisions of the severely diseased cerebral hemisphere. An adolescent or adult patient who harbors a developmental defect, a traumatic or postinflammatory scar or area of local vascular insufficiency with resultant abnormal excitation of the brain, is within the scope of surgical aid.

Subarachnoid Hemorrhages. This condition, like epilepsy, is another symptom which all too commonly is treated as a disease *per se* while the primary lesion remains undiscovered and consequently a potential danger to the patient. The symptom of spontaneous subarachnoid hemorrhage (the epithet excludes from consideration examples of trauma to the central nervous system) occurs commonly in the prime of life. The natural processes occurring at the time of the initial hemorrhage cannot be altered by treatment. But something can be done to decrease the incidence of recurrent bleeding, an incidence as high as 35 per cent to 50 per cent in some series and an incidence which carries a mortality of equal proportion. Such grave figures emphasize the need to pursue investigation of the cause of the hemorrhage. By far the most common cause of bleeding is the rupture of an intracranial congenital aneurysm. Other arterial and venous lesions, blood dyscrasias, tumors, etc., account for the remaining cases which are not due to arterial disease and hypertension. When favorably located, the intracranial aneurysm can be treated surgically. Its locale and environment, its configuration and possible associated lesions can be determined by the use of bilateral visualization of the intracranial circulation—by carotid and occasionally vertebral angiography. The aim of the surgical procedure is to isolate the aneurysm from the normal arterial stream without compromising the cerebral circulation. Other lesions responsible for subarachnoid bleeding are also occasionally amenable to surgical treatment (see Figure 4).

It must be remembered that surgical treatment of such diseases is fraught with uncertainty and risk. However, the risk of an unattended lesion is even greater, and effort must be directed toward these lesions which are remediable. The only way to determine which lesions can be treated is to study every case of spontaneous bleeding.

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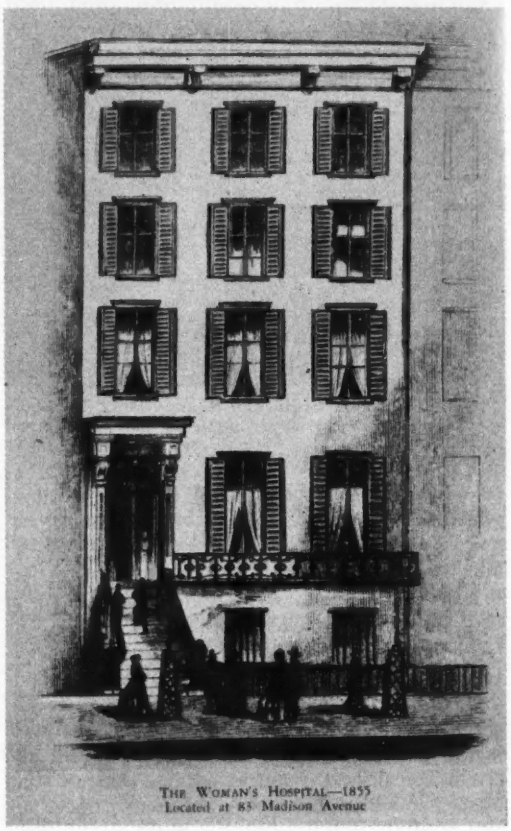
Gynecology Celebrates a Centennial

HAROLD K. MARSHALL, M.D., Glendale

GYNECOLOGY as an independent specialty is just completing its first one hundred years. Until the middle of the Nineteenth Century little was known and less done to alleviate the suffering of women. Gynecologic practice was limited to the treatment of erosion with silver nitrate, leukorrhea with oak bark solutions and uterine prolapse by the employment of a ball pessary. Gynecologic operations were rarely done, which is not surprising when we consider that asepsis, even antisepsis, had not yet been dreamed of; anesthesia was still in the future; and knowledge of clinical anatomy, physiology and pathology was meager indeed. True, the abdominal cavity had been surgically invaded a few times, but only in emergencies and as a last resort, the almost 100 per cent mortality making any other indication out of the question. Obstetrics was chiefly the function of the midwife, and even the obstetrical specialists "were content when they brought a living child into the world and saved the mother; responsibility for future ills being laid upon the gynecologist."[4]

Such was the state of affairs in the gynecologic world at the middle of the Nineteenth Century when events unfolded which brought about the birth of gynecology as a specialty. According to Ricci, "More was accomplished towards the solution of gynecological problems during the last half of the Nineteenth Century than in the previous 2,000 years."[4] The stimulus that brought about this awakening and started this development, according to George Gray Ward, "originated in America, as a result of the genius and historic efforts of Marion Sims. He gave the impulse which upset the do-little conservative treatment of disease of women which then prevailed and opened wide the field of active surgical, scientific and rational methods that are now in vogue."[7]

It was one hundred years ago (May 4, 1855) that the Woman's Hospital in New York, the first hospital in the world "dedicated for the treatment of diseases peculiar to women," opened its doors to the public. Founded by the inspiration and efforts of J. Marion Sims, who came to New York from Montgomery, Alabama, after his successful repair of the, up to then, incurable vesicovaginal fistulae,



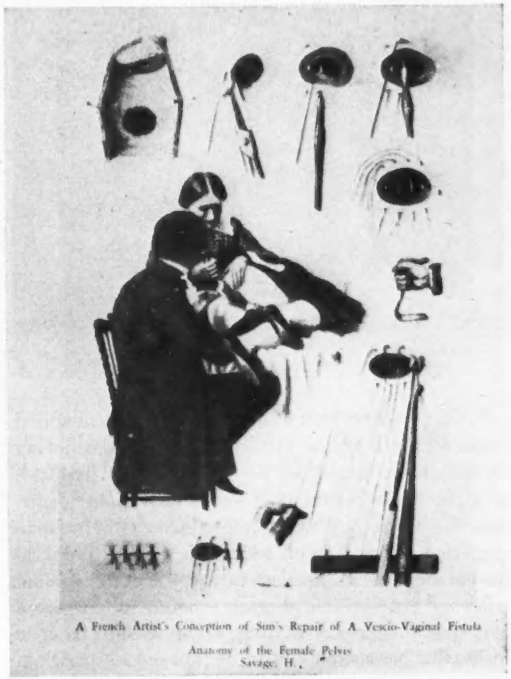
THE WOMAN'S HOSPITAL—1855
Located at 85 Madison Avenue

"the hospital soon became the seat of instruction in gynecology for the medical profession, not only of America, but of the entire world, and was the foremost influence throughout the world in developing and establishing the great surgical specialty of gynecology."[2]

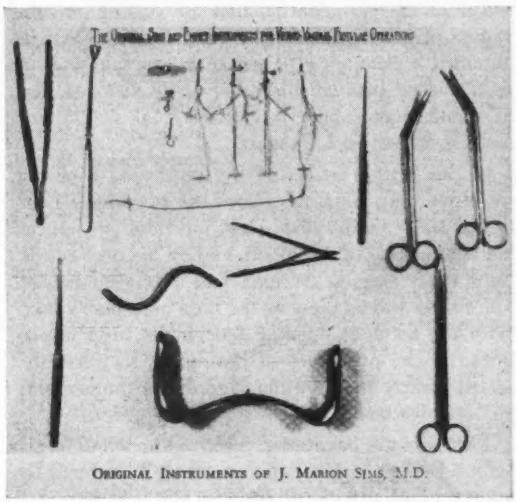
Because of the profound influence of the man and the hospital, today Marion Sims is acknowledged as the father of modern gynecology and the Woman's Hospital as its birthplace. This year, "Woman's," as it is affectionately referred to by those who have basked in her glory and partaken of her knowledge and experience, will celebrate with appropriate ceremonies its century of service to womankind. What a rich heritage it has! For sheer thrill and inspiration, there are few stories in medicine, or anywhere

Chairman's address: Presented before the Section on Obstetrics and Gynecology at the 84th Annual Session of the California Medical Association, San Francisco, May 1-4, 1955.

Dr. J. Marion Sims,—"whose name will be known as long as the English language shall be spoken."
1874



A French Artist's Conception of Sim's Repair of A Vesico-Vaginal Fistula
Anatomy of the Female Pelvis
Savage, H.

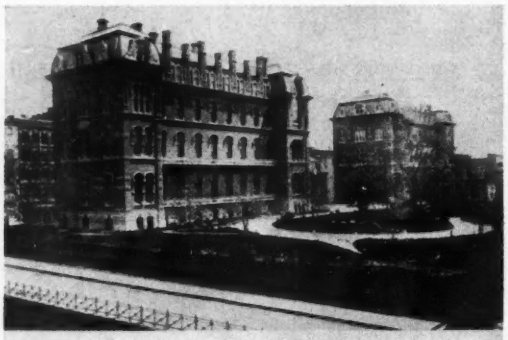


ORIGINAL INSTRUMENTS OF J. MARION SIMS, M.D.

for that matter, that compare with the story that began humbly yet momentously a hundred years ago.

The career of Sims, with its hardships, struggles and, finally, unparalleled success reads like an Horatio Alger success story. Born in South Carolina of English and Scotch-Irish descent, he began his study of medicine with a year as apprentice to Dr. Churchill Jones, an eminent South Carolina surgeon, to whom Sims gives credit for his inspiration for surgery. In 1833 he enrolled and spent one year at the Medical College of South Carolina at Charleston. He completed his final year at Jefferson Medical College, Philadelphia, graduating in 1835.

After graduation, Dr. Sims returned to his home town of Lancaster, South Carolina, to practice. There his first two patients died. Disheartened, he moved to Alabama, first to the town of Mt. Meigs and then to Montgomery where he became known as an able surgeon and prospered. Here in 1837, he removed the lower jaw of a patient without mutilation and in another case the superior maxilla for a tumor of the antrum. He was the first in the South to cure clubfoot, and one of the first to operate for correction of strabismus. In 1845 he reported a successful operation on harelip. These experiences and successes trained and prepared him for the great adventure of his life. It was in the small southern community of Montgomery that he struggled for a cure of vesicovaginal fistula and finally succeeded. In that day the lack of obstetrical knowledge and the infrequent use of obstetric forceps led often to long, obstructed labor, the resulting pressure necrosis of the bladder and anterior vaginal wall giving rise to fistula. Every community had a number of pitiable cases. Surgeons the world over had tried to correct the condition but with very discouraging results—hundreds of trials but only occasional success. The medical profession at the middle of the Nineteenth Century admitted defeat and referred to the lesion as incurable. Thus it was in 1845 when Sims became interested in the problem.



The Woman's Hospital In The State Of New York—1890
The Weymore And Baldwin Pavilions
The Present Site of the Waldorf-Astoria Hotel, Park Ave., N.Y.C.

In that year Sims saw three cases of vesicovaginal fistula within a period of three months. Considering the condition incurable, he dismissed the first two patients. A few weeks later as he was about to dismiss the third patient, a Negro slave, an incident happened which proved to be the turning point in his career. He was called to see a young woman suffering acute pelvic distress due to an impacted retroverted uterus resulting from a fall from a horse. Placing the patient in the knee-chest position, he introduced his finger into the vagina, accidentally elevating the perineum so that air rushed into the vagina, distending and ballooning it out so that he obtained a clear view of the entire vaginal wall. A light flashed through his mind as he visioned how he could thus expose a vesicovaginal fistula and make it accessible for repair.

On his arrival home, having purchased a pewter tablespoon en route, he placed the previously mentioned slave in the knee-chest position, introduced the bent handle of the spoon, and, in his own words, "saw everything as no man had ever seen before. The fistula was as plain as the nose on a man's face. With the fistulous opening seen in its proper relations, all the principles of the operation were presented clearly to my mind. From this moment my high resolve was taken."[7]

That was the beginning. Sims worked four years before he was successful and cured a patient. He built a hospital with 12 beds in his back yard for his patients, all of whom were Negro slaves. His report shows he operated 40 times on three patients and 30 times on one of them during this experimental period before a single cure was effected.

His story is an exhibition of faith, determination and perseverance seldom found in man. We in this day can learn much from his simple story. Failure piled upon failure as weeks, months and years passed. Only a man inspired could have struggled on.

When his physician friends tired and left him, he trained his slave patients to hold the retractors and to assist with operations. Thus, while waiting for the tissues to heal after an unsuccessful operation, a patient would help him operate upon her sister-sufferers.

To keep the bladder empty, Sims developed a tin metal retention catheter. Still failure stalked his every effort. His next innovation was to use lead shots on sutures instead of knots to get snug apposition in accessible areas. But still, as related in his own words, "The operation was mechanically perfect, but with no better results than when it was rude and clumsy."[4] Then came the change which proved to be the difference between failure and success, namely, the substitution of silver wire for silk sutures. Obtaining the special fine silver wire from a jeweler, he was ready, Again, in his own words: "On the 21st of June 1849, it was done. A young colored woman, named Anarcha, who had never murmured at the preceding failures, was placed on the operating table for the thirtieth time, and the silver sutures were applied, with leaden bars and the perforated shot. On the eighth day with a palpitating heart and an anxious mind I turned the patient on her side, introduced the speculum and there lay the suture apparatus just exactly as I had placed it. There was no inflammation, there was no tumefaction, nothing unnatural, and a very perfect union of the fistula. I shall not dwell upon my feelings at this time. At last, I had attained what I had worked for nearly four years; and it was but a few weeks before all the cases were cured that had been the subject of experiment for so long a time. I was anxious to get a few more cases to settle some doubtful point, before publishing to the world my discovery."[4] The *American Journal of Medical Sciences* published in January 1852 James Marion Sims' paper entitled, "On Vesicovaginal Fistulae." Illustrated with woodcuts, it reported six successful cases.

Sims had expended a large portion of his private means to finance his experiments and hospital in those four years, for the patients with vesicovaginal fistula he had kept at his own expense. Moreover, constant mental tension, great responsibility and the daily grind of medical practice had undermined his health and he contracted chronic dysentery. Seeking health in a northern climate he went to New York City and to the second great and important medical adventure in his life.

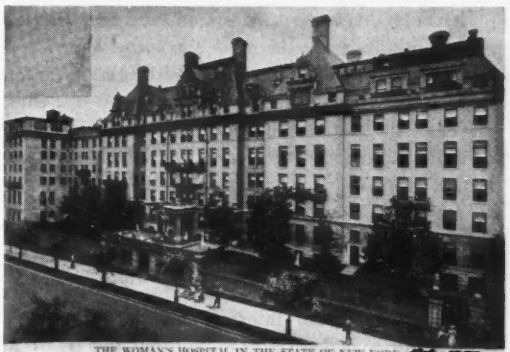
At first he received a warm welcome in New York, all influential physicians joining with him to activate his dream to found a hospital for the care of women suffering with vesicovaginal fistula. But soon

petty professional jealousies arose, and former friends then bitterly opposed his revolutionary ideas. Dr. Meredith Reese protested that there was "no need for a hospital to treat women's diseases as the field was too limited." Anyone, he thought, could apply silver nitrate through a cylindrical speculum to an ulcerated cervix; apply an astringent solution for leukorrhea and insert a pessary for prolapse.[4]

Sims, always a fighter, was undaunted, and with the aid of a newspaperman, Henry L. Stuart, and Dr. John W. Francis, he interested a few influential and farsighted women in the project. On February 10, 1855, some thirty ladies met in St. Mark's Place, drew up a constitution for the Woman's Hospital Association and for a new charitable institution to be known as the Woman's Hospital.

A house was rented at Madison and Twenty-ninth Street for $1,500 a year. Modestly furnished and supplied with a fund of $2,500 for the first year's operating expenses, the hospital was a "going concern." On May 4, 1855, less than three months after the first organizational meeting, the new hospital opened its doors to the public. J. Marion Sims was resident surgeon, and there was a consulting medical board. "Two matrons, one to attend to the domestic concerns, and the other to administer under the surgeon's order to the sick, and a nurse, completed the officers of the hospital." The hospital contained 30 beds. To the poor the beds and all the hospital facilities were free; those able to pay and occupying separate rooms were charged varying amounts from $3.00 to $10 a week. Some rules of the hospital: "All patients desiring to leave must give one week's notice. Gentlemen could only remain twenty minutes in the wards and were not allowed in the evening. Lights were extinguished at 10 p.m. and private rooms using gas after that hour were charged for same." The first patient was an Irish immigrant, Mary Smith, who had a bad fistula, which her physician in Ireland had tried to help by using a wooden "seine bob" which floated into the opening. It had become encrusted with phosphatic deposit. After many operations at "Woman's" she was cured; and she then stayed on as a nurse in the hospital. During the summer months the hospital was closed, as it was felt that wounds did not heal well in hot weather. Anesthesia was not used at "Woman's" until after the Civil War, more than ten years after the opening of the hospital.

On February 9, 1856, when the first anniversary meeting was held, a report was made that in the nine months of operation of the hospital, "sixty patients had been admitted, twenty-one of whom had been discharged perfectly cured and that all the patients still remaining in the hospital (with one exception)



THE WOMAN'S HOSPITAL IN THE STATE OF NEW YORK—
NURSE'S HOME—MAIN BUILDING—THOMPSON PATHOLOGICAL BUILDING

were pronounced by the resident surgeon curable."[2] It is interesting to note that in a "report of all operations performed at the New York Hospital January 1848, to April 1851 (three plus years), not a single gynecological operation had been performed at that hospital."

"While the first patients in the hospital were sufferers from vesicovaginal fistula, various gynecological operations were soon developed, until the fame of the institution as a fountainhead of knowledge for the cure of the many ailments peculiar to the sex became widespread throughout the land, and the hospital became the Mecca of all who wished to perfect themselves in gynecology."[7]

With such interest, the capacity of the original hospital soon became inadequate. The new idea of the surgical approach to gynecological problems was "catching on." Sims became the undisputed leader in the country. Through his efforts, in 1858 the city of New York gave the hospital a plot of land, a square block area on Park Avenue between 49th and 50th streets, the present site of the Waldorf-Astoria Hotel. The site had served as Potter's Field during the cholera epidemic of 1832, and 47,000 bodies had to be removed from the area.

On this site a new hospital, the Wetmore Pavilion, was built. It was opened October 12, 1867, with accommodations for 75 patients. Ten years later a second building similar to the first, the Baldwin Pavilion, was finished and opened. The majority of the beds here were free; others ranged from $6 to $15 a week. All medical and surgical services were still free.

With its greatly increased capacity and facilities, the hospital now assumed its rightful place as the center of the gynecologic world. Here Sims, Emmet, Thomas, Peasley, Noeggarth, Goffe, Bissell with others worked and firmly placed modern surgical gynecology on a secure footing.

The Park Avenue site was sold, and in 1906 the present hospital, the third to carry the name Woman's Hospital, was opened on West 110th Street. Exclusively a gynecological hospital for the first 55 years, in 1910 a maternity department was inaugurated and since that time has become an important part of the hospital service both to its patients and in a teaching capacity. In 1915 two wings were added, one as a nurses' home and the other called the Thompson Pavilion. In 1952, the hospital was modernized. The surgeries were air-conditioned and the interior was in other ways brought up to date. In 1953, joining the trend to mergers and to give the advantages of a larger medical center, the Woman's Hospital became affiliated with St. Luke's Hospital—still, however, maintaining its identity and remaining in the same building on 110th Street.

Now, back to Sims who started this chain of events. What manner of man was he that he was able to revolutionize and so change the order of things?

Dr. Emmet described his great chief thus. "Dr. Sims was by nature a surgeon and one of the most dexterous operators I have ever witnessed. He was bold and self-reliant, never at a loss, and his ingenuity was unequaled. He was in no sense a plodder, for his mind and body were always too restless and active. He was so fertile in resource, when I first knew him, that he perfected scarcely a tithe of the brilliant conceptions passing constantly through his mind; and it was impossible to see him perform the most simple operation without learning something new. In perfecting the preparatory treatment, in devising the needed instruments and by overcoming the difficulties in operating for vesicovaginal fistula, Dr. Sims exhibited a degree of pertinacity seldom seen."[1]

A prominent orator thus appraised him. "He possessed the qualities ideal in the makeup of a truly great surgeon, namely, the brain of an Apollo, the heart of a lion, the eye of an eagle and the hand of a woman."[7]

Another interesting incident recorded by Emmet shows that the physicians of a hundred years ago had problems similar to ours in hospital practice today. "Dr. Sims proposed to open the abdomen for the removal of a pedunculated fibroid. His hospital consultants were Doctors Frances and Mott, who were first disposed to yield to Dr. Sims until Dr. Stevens entered a protest, to wit: That Dr. Sims' views might be all right, but he felt that if Dr. Sims should succeed, by chance, every young surgeon in the land would be ripping open the bellies of young women to ascertain if they had such growths to be removed, and he would oppose such an operation simply on the grounds of humanity."[1]

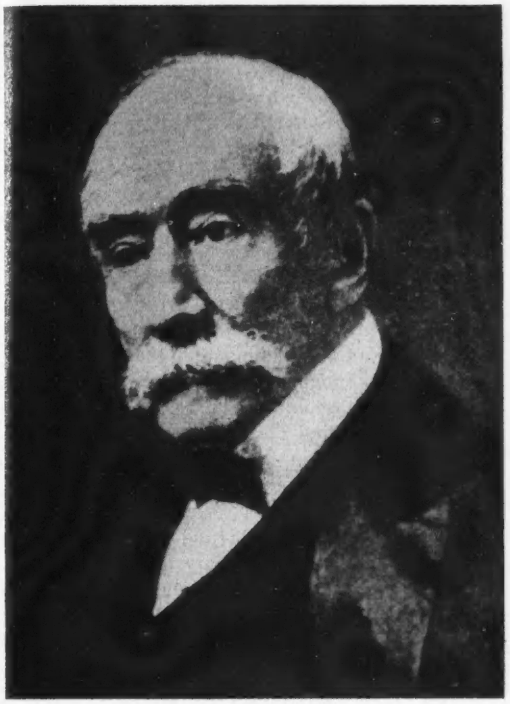
In June 1861, as the Civil War approached, Sims, having Southern sympathies, decided to vacation in Europe. Also, he was making preparations for the new Woman's Hospital and wanted to study hospital construction abroad. While there he interviewed Florence Nightingale, at the time an authority on the "latest in hospital construction." He was received enthusiastically in Ireland, England, Scotland, France and Belgium; and he successfully performed his operations in famous clinics in those countries. He was acclaimed by both profession and royalty. Among his select list of patients in Europe were: Duchess of Hamilton and Lady Mary Hamilton; Empress Eugenie, wife of Napoleon III, and the Empress of Austria.[1]

In London in 1866 he published his textbook "Clinical Notes of Uterine Surgery,"[5] printed simultaneously in English, German and French. Full of original thought and ideas and teaching new and valuable lessons, the book created a sensation. According to James Pratt Marr, this work of Sims "revolutionized modern gynecologic practice." Quoting further from Dr. Marr, "The era of what must properly be called 'Modern Gynecology,' that is operative gynecology, dates, so far at least as the world outside of the Woman's Hospital is concerned, from the year 1866. Sims now had an international reputation as the world's foremost gynecologist."[3]

In 1870, in Paris, Sims helped to organize the Anglo-American Ambulance Corps and, as its surgeon-in-chief, he with seven American and eight English surgeons saw service in the Franco-Prussian War. In charge of a 400-bed military hospital on the battlefield of Sedan, he treated both French and Prussian soldiers.

He returned to New York and the Woman's Hospital in 1872, but resigned from the staff in 1874 because of a rule passed by the lay board of managers limiting the number of spectators at operations to 15. Sims' reputation was such that his operative clinics were packed with both American and foreign physicians. Therefore when the board refused to rescind the rule, Sims departed. In 1880, however, he became consulting surgeon at the hospital and in that capacity he remained until he died of coronary artery disease at age 71 in the year 1883.

Thus ended the life of the world's first great gynecologist—truly, the father of modern gynecology. His genius and inspiration opened up the whole new field of surgical approach to gynecologic problems. While by accident of circumstances his tremendous energies were directed in one specialty, his vision and capabilities and scientific grasp embraced the entire field of surgery. A pioneer in so



THOMAS ADDIS EMMET

many fields, his is the honor of so many "firsts" in medicine—the true test of real genius. In 1846, Sims published an article on "The Nature and Cure of Trismus Nascentium." It was not until 40 years later, however, that his theory and findings were confirmed and accepted. To him goes the honor of originating the operation of cholecystotomy, independently of Robb of Indiana who had preceded him by a few months. With experience gained in the Franco-Prussian War, he was the first and foremost advocate of prompt opening of the abdomen in gunshot and traumatic intraperitoneal injuries to arrest hemorrhage and repair injured bowel. Rabid and bitter opposition to his views—since proved correct—were voiced by the great surgeons of Europe and America. The shooting and slow septic death of President Garfield kindled the flame of the controversy and was the stimulus of his far advanced and scientific principles on the subject. He pioneered operations for cystocele and prolapse and rectovaginal fistula. Emmet credits Sims with first suggesting bimanual examination. He invented the tenaculum, the depressor, the Sims speculum, a flexible copper sound, a uterine elevator and block tin pessaries. He was the first to substitute silver wire for the barbarous quill sutures in perineal repair operations. But, undoubtedly, "Sims' undying fame will rest upon his great original work in the field of vesico and rectovaginal fistula and the founding of the Woman's Hospital."[2]

His great achievement in the cure of vesicovaginal fistula was not priority, as most of the main points stressed by him had been previously advocated by others. He coordinated, rationalized and simplified the technique and for the first time made success the rule.

Sims was the author of some 78 papers on many gynecological and other subjects. In addition his autobiography, "The Story of My Life,"[6] was published after his death.

He was honored by many foreign governments. Among his numerous decorations are the following: Commander of the Legion of Honor of France; Knight of the Order of Isabella the Catholic of Spain; Knight of the Order of Leopold of Belgium; the Iron Cross from Germany and two medals from Italy.

One of the founders of the American Gynecological Society, he was its president in 1880. He was president of the American Medical Association in 1876, and was honorary president of the International Academy of Medicine held in Geneva in 1881.

A statue to his memory was erected in 1894, in Bryant Park, New York City, and in 1934 it was moved and rededicated on a new site on Fifth Avenue opposite the New York Academy of Medicine. In his native state of South Carolina, on the capitol grounds, a memorial statue erected in 1929 carries this inscription, "The first surgeon of the ages in ministry to women, treating alike empress and slave. He founded the science of gynecology, was in all lands honored, and died with the benediction of mankind."

Thomas Addis Emmet, as Sims' assistant, had a wonderful opportunity to acquire his mentor's technique and craftsmanship. For almost fifty years Emmet continued as surgeon at the Woman's Hospital, pioneering in new fields, especially in vaginal plastic operations. As Ricci so beautifully puts it, "The torch so brilliantly lit by Sims glowed even more vigorously in the original hand of Emmet."[4]

By 1868, only seven years after Sims left Woman's Hospital and went to Europe, Emmet had operated on more than 300 patients with vesicovaginal and rectovaginal fistulae.[4] What a tremendous experience! With Sims' 312 cases by the year 1864, this made a total of more than 600 cases by the two surgeons. Compare this to the report of "all operations performed at the New York Hospital, January 1848, to April 1851 (three plus years), when not a single gynecologic operation had been performed at that hospital."[4] What a change 15 years had wrought! Emmet pioneered the study of the lacerated cervix and developed

operations for its repair. He devised a technique of perineal repair which was the standard for 40 years. To him is accorded the credit of being the first great vaginal plastic surgeon of the world.[4] He conceived and devised the hot water treatment for pelvic congestion and inflammation. The vaginal douche was first conceived by him.

Sims and Emmet set the stage, gave the stimulus and inspiration and made the Woman's Hospital the "fountainhead" in the world for gynecological plastic operations—a position it has jealously held through these past one hundred years. "Emmet's art found even fuller mastery in the worthy contributions to plastic surgery of his able successor, Dougal Bissell."[4] Bissell's careful and delicate touch and his respect for tissues, coupled with a master's art of execution, started the present-day concept of tissue planes and the so-called radical repair of vaginal hernias, rather than the "roll-in" procedures of his predecessors. J. Riddle Goffe contributed in many fields, but will be remembered most for the development of a technique for vaginal hysterectomy as a method for treating genital prolapse. Byron Goff clarified our views on vaginal anatomy and gave us a simple and effective method for perineal repair.

George Gray Ward, chief surgeon at the Woman's Hospital from 1918 to 1938, was a man of dynamic personality. Dr. Ward's greatest contributions were the reorganization of the hospital staff, the standardization of its procedures, the improvement of hospital records and the establishment of the annual audit of scientific results. One of the first in this country to use radium in the treatment of cancer of the cervix and uterus, he was an authority for a quarter of a century in this field. Those who had the privilege of working with him (the author among them) both feared and revered him. A hard taskmaster, he had no patience with incompetence or half effort. He was a fine clinician and teacher; and took great pride in those men he helped to train. Member and at one time or another president of almost every society in his field, and one of the founders of the American College of Surgeons, he was one of the foremost American gynecologists since the turn of the century. He added additional laurels to the fame and standing of the Woman's Hospital in which he took such pride. True to the traditions of Woman's, he excelled in vaginal plastic operations and wrote extensively in this field. His "cystopexy," "rectopexy" and vaginal hysterectomy techniques were widely cited. He was one of the first to call enterocele to the attention of the profession and his method of repair is a standard procedure today.

With Dr. Ward's retirement in 1938, Albert H. Aldridge became chief surgeon of the hospital and he has continued in that capacity to the present. Under his able leadership and with help from such capable men as Ralph A. Hurd, Ralph L. Barrett, J. V. Davies, Arthur J. Murphy, George Bemis and others, the Woman's Hospital has continued to wield important influence in the gynecologic world.

This year we join with fellow-specialists and physicians the world over in a salute to "Her Majesty," that great institution, the Woman's Hospital, the mother of modern gynecology, as she proudly celebrates one hundred years of unparalleled service to womankind and the medical profession. This centennial year finds her with a rich and noble past, holding her head high and still occupying a leading position in present-day gynecology—especially in that field of vaginal plastic operations in which the members of her staff have pioneered so long. Section Nine, of the articles of incorporation of the hospital, adopted one hundred years ago, reads: "The primary object of the hospital is the direct relief of suffering humanity. The second object is the extension of this relief to the widest possible degree by using it as a school of practical instruction of the medical profession."

True to her birthright, so nobly won for her by Sims and Emmet and carried on by those dedicated physicians who have followed in their footsteps, the hospital has carried on her heritage and fulfilled that pledge by sharing and giving to the profession her secrets, knowledge and benevolence. How well she has lived up to her avowed purpose. As she embarks on a second century of service, may she continue as nobly to serve both patient and profession.

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ACKNOWLEDGMENT

Acknowledgment is hereby made to J. Marion Sims' autobiography, "The Story of My Life"; to J. V. Ricci's "One Hundred Years of Gynecology" and to James Pratt Marr's "James Marion Sims" for much of the background information for this paper.

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Reading Disabilities in Children

A Symposium

CHAIRMAN:
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PARTICIPANTS:
KENNETH A. GROW, M.D., *Beverly Hills*
HALE F. SHIRLEY, M.D., *San Francisco*
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Introduction

ARTHUR JAMPOLSKY, *M.D.*, San Francisco

POOR READERS are a problem for ophthalmologists, pediatricians, psychiatrists and educators because the problem may involve the eyes, the ears, personality disorder or teaching method. Several questions present themselves; namely: Is the problem exaggerated out of proportion to its value; is the increase in interest and awareness a result of a real or apparent increase in numbers of poor readers? Certain it is that the problem is not new. It is a matter of degree and of renewed interest by doctors, educators, overworked teachers and irate parents. The blame has been placed upon teaching methods, eye and other physical defects, social and home conditions, and television. Each discipline naturally tends to emphasize its own tenets in relation to the problem, or to ignore responsibility in connection with it, or shift responsibility.

It becomes obvious that it is a multifaceted problem involving several disciplines. Further logical and acceptable questions that may be posed are: Is the real or apparent increase in numbers of poor readers a product of teaching methods, increased demands, emotional problems, neurological disorders or physical defects? How does one diagnose cause and effect? What are the prophylactic measures and treatment and by whom should they be rendered? What may parents do to help, or is it preferable that they not try to help?

Although much is known about the various factors involved, there is frequently a lack of communication or exchange of ideas. The present panel has been selected to present a broad approach to the problem because of their special training and experience. It is desirable to see what convergence or divergence of ideas there may be by discussing the points of similarity or dissimilarity.

The panel members are: (1) Dr. Lucie Lawson, psychologist and remedial reading specialist; (2) Dr. Kenneth Grow, ophthalmologist; (3) Dr. Hale Shirley, psychiatrist; (4) Dr. Leo Cain, educator.

Ophthalmological Factors

KENNETH A. GROW, *M.D.*, Beverly Hills

READING DISABILITIES might not be considered a problem for ophthalmologists, but it becomes a problem for them on the same basis as any systemic disease with ocular manifestations. Moreover, ophthalmologists frequently are the first to be presented with problems of reading disability. Many teachers and parents believe that because a child is unable to read, he probably has something wrong with his eyes. Hence he is referred to an oculist for an eye examination. It is easy to do a thorough examination, to find that glasses may or may not be needed and discharge the patient. However, the responsibility is not so easily discharged. A few simple questions may uncover the real problem of reading disability.

Reading disability starts as a problem for the educator, who should determine if the proper method of teaching is being used. The child having the disability could have been referred to his family physician or pediatrician to see that his general health does not impede his learning; to an otolaryngologist to establish that adequate hearing exists, or to a psychiatrist to evaluate mental ability and mental health.

Reading disabilities may be generally classified as *specific* and *nonspecific*.

The term *specific reading disability* is used for cases in which there is confusion in the recognition of language symbols, with reversals, inversions, omissions, substitutions or other faulty interpretation.

Presented before a Joint Meeting of the Sections on Eye, Ear, Nose and Throat, General Practice and Pediatrics, at the 84th Annual Session of the California Medical Association, May 1-4, 1955.

Nonspecific reading disability is used to identify cases in which ocular abnormalities, low intelligence, emotional or other factors prevent normal progress in learning to read.

Ocular abnormalities responsible for poor reading are easily recognized; and if a child has average vision, reading difficulty cannot be considered an eye problem. It is obvious that if the visual acuity is reduced 50 per cent or more, the child will have difficulty in interpreting symbols because he cannot see well, just as a deaf child will have difficulty with pronunciation. However, the effect of moderate refractive errors has been grossly exaggerated. Except in cases of pronounced refractive errors, a child's power of focusing is sufficient to give adequate vision. Indeed, slight myopia may even be an advantage rather than a disadvantage in reading.

The presence of muscle imbalance or "crossed eyes" (provided there is normal vision in one eye) has little or no effect on reading ability, since vision in one eye is adequate for reading and the image in the nonfixing eye is suppressed so that there is no confusion or "incoordination." Depth perception, variation in image size as seen by the two eyes, and eye movements have been ruled out as a contributing cause.

Once an eye problem or other cause for nonspecific reading disability is ruled out, how shall we recognize the specific reading disability? It occurs more frequently in boys than in girls. Children who have such a disability are of average or better than average intelligence but there is a disproportionate retardation of reading skill, often associated with poor writing and spelling.

They may be normal or above normal in arithmetic, art and other subjects where reading is not essential. There is a high incidence of left handedness, or ambidexterity in these children, with a confusion between right and left that is out of all proportion to that normally seen. This is the so-called "spatial confusion" which causes the child to transpose or confuse certain letters such as *b* and *d*, and *p* and *q*. Short words such as *was* and *saw*, *on* and *no*, *not* and *ton*, are reversed and there is confusion between words like *dog* and *boy*, *stop* and *spot*, and numerous others. Confusion of this type is relatively normal in all beginners but it is usually outgrown with the establishment of correct left to right sequences. Those with abnormal spatial confusion will have difficulty overcoming this without special training—they have poor visual recall (*i.e.*, ability to remember what they have just seen) and hence, there is a pronounced barrier in learning to read. The severity of the abnormality varies greatly. Some children reverse letters, parts of words, or even whole words. More severe forms involve upside-down writing or drawing, or mirror writing.

Modern methods of teaching children to read place most of the emphasis on visual association. In the "flash" method, whole words are flashed on a card or screen for the child to learn. Frequently, pictorial associations are included. Since phrases and short sentences can be learned as quickly as words, they are used. Obviously, visual memory is of the utmost importance. The emphasis is on speed and on "learning by looking"—which is catastrophic for a child with spatial confusion and poor visual recall, for he is totally unable to learn by this method alone, regardless of the intelligence quotient, persuasion or compulsion.

Many children no longer learn the alphabet, as attested by the increased use of the illiterate "E" or kindergarten charts for vision testing. Bakwin said that 10 to 15 per cent of public school pupils have some reading disability and that it is the major cause for school retardation. Gates stated that reading disabilities are responsible in 99 per cent of the failures of pupils in the first grade, 90 per cent in the second grade and 70 per cent in the third grade.

A return to the earlier concepts of teaching is essential to these children. The earlier methods started with the alphabet, built this into combinations of simple sounds or syllables, then into words that were seen (visual), spoken (phonetic), heard (auditory), and written (kinesthetic). Some children need to hear the word as well as see it, to break it up into parts and say it, and to feel it by writing it. It is interesting to note that a child may write a short word or syllable reversed, but rarely says a word backward. The speech, hearing, and memory association prevent this.

Unquestionably, a child of normal intelligence who wants to read, but cannot, becomes subject to secondary conditions such as stuttering and emotional behavior problems. Soon the teamwork of all of the previously mentioned specialists may be required to untangle cause and effect. It is not at all unusual for the consequences of the specific reading disability to assume greater importance than the original problem. One of the tragedies of this condition lies in the fact that many children have been labeled as mentally deficient—and treated accordingly.

Diagnosis is not difficult but it cannot be made by a person who does not think about the problem or know about it. Assuming that there is no medical problem, a disproportionate inability to read, write or spell in otherwise intelligent children who are left-handed or ambidextrous should immediately alert the examiner.

One of the first questions should be, "How do you do in reading?", "In arithmetic?" A parent can often tell you if there is a tendency for the child to transpose certain letters and words. Once

such a diagnosis is made or suspected, a letter to the teacher or parent with a recommendation that remedial reading should be instituted is all that is needed of a physician. Many large cities now have remedial reading clinics that do an excellent job. In smaller areas the parents and the school may have to handle the special training.

As has been said, prevention of such casualties probably lies in a return, to some degree, to the older methods of teaching. Some children will do well with any method. It is certain that not all children will do well if given only one method. Since the majority of children learn rapidly under present systems, it can be argued that the greater good should be served. But everyone probably agrees that the minority should also be considered. In this way, every child will have an opportunity to find his own particular road to reading proficiency.

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Etiology and Emotional Factors

HALE F. SHIRLEY, *M.D.*, San Francisco

To MAINTAIN PERSPECTIVE concerning reading difficulties, it is worth while to remind ourselves that for at least 99 per cent of the million years or so since he emerged from his simian ancestry, *genus homo* lived his life without the ability to read and write. It was, perhaps, not more than two hundred generations ago that *homo sapiens* began to use visual symbols to any great extent to communicate observations, experiences and ideas from one person to another and from one generation to the next—a development that contributed fundamentally to the rise of civilization. Until recent times, however, the ability to read and write was acquired by only a few who happened to have a special opportunity to do so.

In our western civilization, the assumption has gradually become prevalent that everyone should learn to read and write. Not everyone is expected to become a mathematician or concert pianist, but everyone is expected to become a good reader. Reading has become a basic tool in modern living. It has become indispensable for higher education. Not only a college education but progress in high school subjects has become almost completely dependent upon the student's ability to read fast, to read much, and thus to obtain ideas, facts and implications contained in endless sequences of visual symbols which number in the tens of thousands.

In our present American culture in which social and professional success is popularly measured by the ability to compete successfully, in which standing in school is largely dependent upon the youngster's ability to accumulate facts through the avenue of reading, and in which every up-to-date parent wants his offspring to acquire the advantages of higher education, parents, teachers, and even classmates become tremendously concerned about the child who has trouble learning to read, and aroused emotions not guided by patiently acquired knowledge too often dictate remedial measures which prove to be ineffective and even harmful.

Seldom do we stop to think how wonderful it is that anyone can learn such an exceedingly complicated process as reading. Instead, we rejoice in the low percentage of illiteracy—only to resolve to make it lower. Ambitious parents give their children reading lessons before they start to school. Schools, with certain exceptions, introduce reading at about the age of six. Parents become alarmed if schools, in discussing or planning curriculae, do not keep reading and writing at the very core of primary education. Truant officers try to make certain that all children of school age are in school.

Failure of a child to learn to read the first year or two in school tends to reflect adversely either upon his intelligence and family background or upon the competence of his teachers. Parents, alarmed, puzzled and defensive if their child does not do satisfactorily in reading, begin the process of proving to themselves and others that they do not have a defective child. They begin to tutor and put the pressure on at home. The child may have many capacities which are obviously normal or even superior and which might be cultivated, but these are lost sight of, and all attention, effort and concern are focused upon the child's one glaring shortcoming: If he could just learn to read and write, he would be all right!

If home pressure fails, the most comfortable way for the parents to deal with their feelings of frustration is to blame the teacher. The teacher, then, under parental and perhaps administrative pressure, begins to feel anxious. The most effective way, often, for her to deal with her feelings of frustration is to put the blame on the child: He could learn to read if he would only try, but he won't try!

From the Departments of Pediatrics and Psychiatry, Stanford University School of Medicine, San Francisco 15.

The child, thus, finds himself in a dilemma which he cannot understand and from which he can find no satisfactory avenues of escape. He finds himself the victim of concern, anxiety and resentment, and perhaps punitive measures, with no way of finding relief, status or approval. He begins to feel alarmingly different from his classmates. He loses self-confidence and self-esteem. He may feel rejected, looked down upon and disliked. In defense, he may break out with aggressive, hostile behavior. Or he may become dominated by chronic anxiety, acquiring a variety of nervous habits, withdrawing from social activities, resorting to physical complaints or indulging excessively in day dreaming. He may eventually succumb to defeatism, losing interest in school work, paying little attention to class activities and refusing to try. The longer he remains unable to progress in reading, the more deep-seated becomes his emotional disturbance and also his aversion to trying.

For many years now—at least 25 in the author's personal experience — physicians, educators and parents have realized that reading difficulty is a common and sometimes puzzling educational problem. Hypotheses and theories as to the cause of reading disability have been advanced by the dozen, and each implies its own specific solution. This symposium, however, is evidence that the problem is still with us and that we have not discovered any panacea.

What do we know about learning to read and the difficulties which children encounter in their efforts to do so?

Well, when we stop to think about it, it becomes obvious to all of us, I am sure, that learning to read is a very complicated mental process with many components, want of any one of which may be the cause of failure. Reading may not seem to be complicated to those of us who after 20 years or more have mastered the process to our own satisfaction—and incidentally, it is those of us who have eventually learned to read well who insist that we maintain our culturally inherited but monstrously illogical method of spelling which to so great an extent makes learning to read difficult for anyone. But even if we had an alphabet with a symbol for each sound, and even if words sounded like they are spelled, reading would still be a complicated process with many aspects to consider.

There is no one cause for reading disability. There is no one etiological factor which is found uniformly in poor readers and is likewise uniformly absent in good readers. Children fail to learn to read for various reasons, and in each child the cause or combination of causative factors must be individually determined.

To learn to read, of course, a child must have adequate vision. Dr. Grow has discussed the incidence of visual anomalies found in reading disabilities and the role of the ophthalmologist in their diagnosis. While poor vision is seldom found to be the main cause of a reading difficulty, refractive errors, muscular imbalances and poor oculomotor habits can be contributing factors, and their correction, if present, should be an essential part of a therapeutic regimen.

Physical ill health is also seldom found to be the sole cause of failure to learn to read, yet chronic illness, malnutrition, fatigue and hearing disorders can interfere with school attendance and general performance, thus contributing to the problem.

To learn to read, also, the child must have the mental capacity necessary for reading. About one per cent of the population does not have sufficient intellectual capacity to learn to read at all. Another two per cent can learn only the rudiments of reading. About 15 per cent of children who reach school age will not be ready for reading until they are seven or eight years old, and most of these will never become capable of achieving much beyond the sixth grade level of reading. In most of these children, slowness in starting to read is only one aspect of a slower than average intellectual development, and the child's ability to read keeps pace with the development of his other mental abilities.

For most of these slow learners, special remedial reading methods are not necessary. Such children will begin to read when they are ready to do so, provided they are protected from undue competition and the frustration and disgrace of failure. If they are allowed to progress at their own rate, most of them will develop to the fullest their capacity to read, limited though that capacity may be.

Not all children who are not ready to learn to read at the age of six or even seven, however, are mentally retarded. Many measure as normal on general intelligence scales, and some even as superior. It is now well known that not all of the developmental aspects of a child progress necessarily at the same rate. There are individual differences in rates of nervous system maturation, not only in general but in specific functions. One child who eventually rates in the same intellectual classification as another, for instance, may be slower to walk; another will be slower to talk; another will be slower to learn to read.

If parents and teachers can be encouraged to wait watchfully and patiently until the child displays evidence of readiness and desire to read, most children of normal intelligence will then learn naturally and easily, often soon catching up with the children who get an earlier start. If, on the other hand, the child is pushed into reading before he is ready for it, he is likely to develop emotional tensions and

negative attitudes which may further retard his progress or even prevent him from eventually making use of the capacity he has acquired. The result is a nonreader now on an emotional basis.

Dr. Grow has mentioned a specific kind of reading disability which has been variously called visual aphasia, word blindness, developmental alexia, dyslexia and strephosymbolia. He has described the clinical picture. Child psychiatry textbooks have contained a discussion of this condition for over two decades,[2] and in recent years frustrated parents have latched onto it as the answer to all reading problems.

The cause of this kind of reading disability is still a controversial matter. It was at first assumed that there must be neurological impairment, that there must be cortical deficit in the visual associative areas or pathways, but proof of this theory has not been forthcoming. Much has been written also about the possibility that severe reading disabilities are due to alternating or mixed cerebral dominance with a resulting confusion as to spatial orientation and relationships, manifest in such symptoms as a tendency to reverse letters, syllables, and small words, and sometimes in mirror reading and writing.[3]

Studies have shown that a higher percentage of children who are nonreaders than those who learn to read readily do show manifestations of confused cerebral dominance such as ambidexterity or learned right handedness in a naturally left-handed person, or mixed cerebral dominance such as is present when there is right handedness and left eyedness, or left handedness and right eyedness.

It is probable that confused cerebral dominance is an etiological factor in some cases of reading disability, but it cannot be the sole factor in all, for many nonreaders do not show it, and some who do, normally learn to become good readers.

A specific and relatively poor visual memory is said to be another condition which handicaps some children in learning to read by the now widely used "sight" or "flash card" method of teaching reading. Experiment has shown that many if not most children learn to read most rapidly by learning to associate meanings with whole words. There are those, however, who do not learn by this method, or do so with great difficulty. Such children, like those who show evidences of strephosymbolia, learn more readily, at least at first, by utilizing their auditory and kinesthetic avenues of learning. They learn to read best by the so-called "phonic system," learning the sounds of the letters and syllables so that they have a method of sounding out the word when the pronunciation and meaning is not otherwise obvious to them; also, through tracing or copying, by learning the feel of the letter and syllable in relation to its sound as well as to its sight.

The upshot of this matter is that there is not just one proper way to teach reading. Most children seem to be able to learn to read satisfactorily by any current method. Probably most learn to read most readily by a combination of methods. There are those, however, who learn to read best by one method or another, and the problem is to fit the method to the specific need of the individual child.

For many of these children in whom special reading measures are indicated, an important part of the remedial process is the relief of secondary emotional disturbances. Not infrequently the least important part of the tutoring, especially in the beginning, is the specific remedial techniques used, the success in the early stages depending, rather, upon whether or not the pupil likes his tutor and whether the tutor can stimulate the child to want to read, thus enlisting his best efforts; also, whether the teacher can show the child that reading has its own rewards.

The causes outlined so far, however, do not explain all reading disabilities. There remains a sizable number of children who do not learn to read by the methods so far outlined for the reason that the inability to read is primarily the result of emotional disturbance.

The importance of emotional and social maladjustment in the etiology as well as in the results of severe reading disabilities has been given more and more attention in recent years. Gates[1] found emotional disturbances in 75 per cent of a series of children studied, and felt that they were causative in 19 per cent. Robinson[5] found them in 41 per cent of a carefully studied series of 22 and concluded that they were causative in 32 per cent. From her study, Robinson concluded that home and family relationships have not in the past been given the emphasis they merit.

Certainly, the child who goes to school before he has solved the elementary social and emotional problems of home living, who is profoundly disturbed in his parental and sibling relationships, or who is driven by overwhelming anxiety, jealousy or hostility toward children or adults is not likely to be able to apply his attention and abilities to those school tasks, such as reading, which require a certain achievement of emotional and social maturity. Also, the child who must accommodate himself to a school atmosphere which is radically different from the one to which he had become adjusted at home may be severely handicapped in his early tasks of academic achievement.

There are children, too, whose reading disability, upon sufficient study, proves to be quite clearly a neurotic symptom.[6] Occasionally a child is observed

whose normal curiosity and aggressiveness in learning was so undermined in later infancy that learning in general and sometimes reading in particular arouses more anxiety and guilt than he can tolerate. In others, failure to read solves a more or less unconscious emotional need, as for example when refusal to read gives the child the attention that he feels he otherwise lacks, or serves as a method of punishing those who, he feels, are overly demanding of him.[4] The best hope of such children is usually to be found in psychotherapy. Remedial measures are usually ineffective until the emotional conflicts have been resolved.

As to the treatment of reading disabilities, two general comments seem indicated from the material so far presented. First, as in all fields of medicine, effective treatment depends upon correct diagnosis. If after two years of schooling a child is failing to learn to read, a comprehensive diagnostic study should be made, all of the possible etiological factors being kept in mind and evaluated. Second, the solution to many reading disabilities is to be found in the gradual development of the mental health facilities of the schools and the psychotherapeutic resources in the community. In many schools and communities such facilities and resources are inadequate to the problem with which the schools are confronted.

Top educators and mental health authorities have become well aware of these inadequacies, but the barriers to effective communication and cooperation between the various disciplines involved are only now beginning to yield to the pressures of the need, and the public has not yet displayed its willingness to support the development of special facilities for the emotionally handicapped as it has for the physically and intellectually handicapped.

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The Schools and the Methods Of Teaching

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THE PROBLEM of the teaching of reading has been a subject of considerable discussion during the last few years. A great deal of this discussion has arisen from studies which show that there is a lack of interest and a lack of ability in reading among our children and youth. It has also been stated that this condition did not seem to exist a generation ago, and that the schools are delinquent in providing an adequate education for our future citizens.

The schools are cognizant of this problem and are highly concerned about it.

What persons who are not professionally concerned with education often do not recognize is that the school problem today is not the same as it was a generation ago. Twenty-five years ago the school was an institution which weeded out the inept and only retained those who could achieve in terms of certain set academic standards. When today we have 98 out of every 100 pupils moving from the eighth grade into the ninth in contrast to former years when only one out of every two moved from the fourth grade into the fifth, we can readily see that the school is now tending to retain the great majority of school age population up until about the age of 16. This means that it has a much wider range of individual differences with which to deal. No longer do the children who formerly failed to learn to read stop school and go to work. They are by law required to remain within the school population.

Another factor that has played an important role in relation to reading is the great increase of stimuli in the child's environment. Radio, movies, television and other visual and auditory ways of obtaining information have appeared and become universal. Thus individuals can obtain information without reading, and as a result for thousands of people reading does not play a role of major importance. The schools are also confronted with the problem of the rapid growth of the school population. This has been particularly true in California where increase in population has resulted in overcrowded classes, double sessions and an inadequate supply of well trained teachers. This has seriously affected the quality of instruction, particularly at the elementary level.

In facing these and other similar problems, the school has attempted to develop a program of read-

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ing that will be beneficial to all the children it is required to serve. In developing this program it has had to be dependent upon the cooperation of the home, the community and the professions including psychology, medicine, social work and nursing. In other words the teacher has become part of a team of individuals who are interested in the reading problem and with whom she is working in order to develop the best possible educational program. No longer is reading considered a purely mechanical learning process where an individual learns a skill and is expected to use this skill in a wide variety of situations. Research has shown that the emotional adjustment and the physical characteristics of the child as well as the attitudes of the parents are particularly important in whether or not the child learns to read adequately. In developing this program the teacher plays a key role. The school administrator also realizes that reading is not a skill that is simply taught in a reading period but is a problem which must be considered by all teachers of all subjects at all levels. He also realizes that, as in the development of any other skill, a certain proportion of his students will have to have specialized and intensive help and that such facilities should be provided through the school and the community.

Here are some of the factors with which the school has concerned itself and in which teachers of our schools have taken leadership:

1. *Development of real understanding of the reading process and of the developmental sequences in learning to read.* Educators have done much research in such problems in an attempt to develop an understanding of what is called "reading readiness." It is well known that not all young children are ready to read at the same chronological age. Developing maturity is a complex operation and before reading is taught a child must be both physically and psychologically prepared to accept the responsibility of this learning problem. This means that not all youngsters necessarily learn to read at the age of 6, which is the common age for entering school. Some will learn to read earlier, some much later. This fact is much misunderstood by parents and others who sometimes do not recognize that reading must sometimes be delayed in order to prevent a child from getting a bad start and thus experiencing frustration during the remaining years of his school life. It is also known that reading development parallels the development of intellectual and social maturity. If in the planning of the school curriculum these factors are carefully considered, many of the reading problems that children have can be successfully prevented.

2. *Study of the methodology in the teaching of reading.* This, of course, has been widely discussed. Some persons advocate that reading should be taught phonetically; others believe that teaching through words and phrases is better; others favor a motor or kinesthetic method. Several other methods have also been suggested. A good teacher who understands the reading processes and is aware of the individual differences that exist among children and youth knows that no one method will be successful with all children. The teacher who knows her children will be able to adapt successfully, in most cases, the method that is most effective for the particular child. It should be remembered that the method of teaching reading is only a means to an end and not an end in itself, and that the method to be used is one that fits the situation at hand.

3. *The recognition of the importance of providing a positive and constructive psychological atmosphere.* If the teaching of reading is successful, the atmosphere in which reading is taught must be positive. Research has shown that the child who is motivated to learn to read and who is interested in reading learns best. If there is no incentive to learn to read, it is highly probable that not much progress will take place. Therefore, the teacher must make reading interesting and at the same time make the child feel that reading is important to him. It is sometimes difficult to show the importance of reading to a child if the home totally lacks an atmosphere which encourages reading and the parents themselves do little reading.

4. *The encouragement of individual face-to-face guidance.* The good teacher will attempt to help individually a child who has a reading problem. The great majority of our teachers are doing this in spite of the fact that they have large classes and long hours. Here is where the teacher has to seek help from other professional groups. She may need the help of a social worker or psychologist on the emotional problems of the child; she may need the help of a physician to alleviate certain physical or emotional difficulties; or she may need the help of reading specialists who can work intensively with the child to help him with both his immediate and long term problems. The good teacher knows when to seek help. She is often most frustrated when she does not find this help available in her school or community.

The alert school system also realizes that the problem of the teaching of reading is one in which much progress is being made; that as a modern school system it must keep abreast of the times in terms of new developments in the teaching of reading. It is only by continuous research in this field that present programs are going to be improved. We must look to the future and not simply rely on what we consider to be sound practices as defined by the present and the past.

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Corrective Measures

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READING is a subtle and complex process—a composite of skills or abilities. It involves a complicated sequence of sensation, perception, comprehension and, finally, utilization. That difficulties should arise in the acquisition of this process is indeed not strange.

Any attempt to prevent or correct such difficulties is necessarily based on careful consideration of possible etiological determinants. Certain causal factors have already been mentioned in this symposium, and others might be included. There is what Bakwin and Eustis term the "specific reading disability," characterized by reversals and mirror reading and frequently associated with confusions in lateral dominance. Certain findings suggest that a slow rate of neuromuscular maturation may be involved in the language disabilities of some children. This slowness may be general or it may reflect itself most conspicuously in certain skills, such as reading. Also mentioned is congenital alexia, a developmental variation comparable to the language dysfunctions found in an aphasic adult.

According to very recent research, retarded visual perceptual development may account for the failure of some children in learning to read. These youngsters, of average or above-average intelligence, appear to lack the ability to discriminate between words and other symbols. Hearing impairments, visual defects, poor general health, inadequate environmental stimuli for interest in reading, inappropriate teaching methods, emotional disturbances—all may serve as deterrents to reading.

Most investigations, however, have pointed to the probability that not one but several or a constellation of related causes produce most reading difficulties. Careful studies have demonstrated no clear-cut factors which appear only in nonreaders and not in good ones. Hence much care must be exercised before concluding that the anomaly exhibited by a nonreader operates as *the* cause of his reading failure.

Perhaps paramount in evaluation of a reading difficulty in the primary grades is the question: Is this child ready to read? Existence of wide differences among children entering school is almost universally recognized. Just as children do not stand up or walk at the same time, or begin to talk at the same age, so children may be slow in developing certain functions involved in reading. Their sensory apparatus, such as is involved in visual-perceptual discriminations, may be late in development; their motor skills may be immature; they may lack the experiences which stimulate a desire to read; they may have difficulty in following directions; they may have poor memory; their attention span may be brief.

Most children are ready to read by 6½ years. However, a substantial number are not ready until 7 or 8 years. In fact, it has been estimated that, in a typical school population, 25 to 30 per cent of the children in the first grade are not ready for the regular reading program. On the other hand, there is the occasional child who is cheerfully and glibly ready to read at 5 years.

Susie may learn early and easily. She may read simple words in kindergarten and read with relative fluency in the first grade. Jimmy may start later—perhaps the second grade, even the beginning of the third—and still learn without difficulty. Again, Mary and Tommy may begin late and progress effortfully. In other words, readiness is not dictated by the calendar or by the grade.

The second basic consideration in the correction of reading problems involves the recognition of and provision for individual differences in reading needs. One group of children with reading difficulties may be the "late maturers." Many of these children, considered retarded readers, will be aided by a program of developmental instruction which adapts to their learning needs, which provides more success than failure, which alleviates the tensions and anxieties regarding their previously low achievement. Essentially such a program is developmental rather than remedial. The child needs appropriate aid to develop skills rather than to remedy defects.

For other children thorough diagnostic studies and special differentiation of techniques will be indicated. Many methods for the teaching of reading have been developed. There are the so-called visual methods, whereby a child learns to recognize the configuration of a word. Phonics entails a system which enables a child to pronounce or identify a word by the sounds. Structural analysis teaches the child to break down the word into smaller units. Kinesthetic methods emphasize tracing and writing the word or phrase.

For answering the frequent query, "Which method is best?", we may turn to evidence from research in the psychology of learning. Detailed experimentation and empirical observations over the past 20 years have pointed to the conclusion that there probably is more than one kind of learning. Different kinds of learning may take place simultaneously or at different times. Learning may occur according to both behavioristic and gestalt principles. More-

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over, individuals differ in the learning cues to which they respond most readily.

Applied to reading, then, it is apparent that a variety of learning methods provides a child with a variety of tools for recognizing words. He needs different methods of attack to serve different types of words. For example, phonics will help him on words like "cat" and "man" but will leave him stranded when he is confronted by "though" or "through." Structural analysis will help him to find the "in" in "winter" but will be misleading when he finds the "me" in "come."

Thus it would appear ill-advised to contrapose phonics and flash cards, or a kinesthetic method and a phonetic method. No one technique is infallible. Probably no matter what approach or methods are used, children will learn at differing rates and in varying degrees. Repeatedly noted is the fact that the child who can combine several methods of attack on an unfamiliar word, is usually found to be the most successful reader.

Again, as was suggested previously, individual children vary in their learning needs. Some respond most effectively to auditory cues; for them, phonics will be most useful. Others respond to visual cues; for them, visual recognition is particularly valuable; for still others a kinesthetic method is needed.

It appears that there is no prefabricated plan or panacea for all reading problems. The same prescription cannot be given to all children.

The particular learning pattern which is most relevant for a given child may be indicated by detailed evaluation of that child's particular strengths and weaknesses. Diagnostic reading tests may reveal the trouble-spots in his reading—be it his rate of reading, vocabulary level, his techniques of word recognition and analysis, his visual memory, his memory for orientation of forms, auditory memory, oculomotor control and attention. Moreover, his behavior and attitudes during the tests may reveal habitual work patterns and emotional reactions toward the reading.

Other considerations in a program for a child with reading difficulties are the attitudes of the adults in his environment. The child should not be labeled a nonreader. It is unfortunate indeed if he hears himself described often as "the action-type, not the reading type." He is thus presented with a picture of himself as an individual who cannot or will not read. With such a label he may well abandon all effort. He could hardly be expected to show an interest in reading in the face of such apparently unanimous public opinion, and he may become acquiescent to his status as a reading failure. He should feel that he is potentially a reader, if not actually one at the moment.

Sometimes the acquisition of some reading ability, albeit a humble one, may bolster the child's previously tattered ego and may in itself reduce some of the emotional tensions associated with reading.

As a corollary, there are those occasional children whose nonreading has become a source of satisfaction—a secondary gain, so to speak, which they may be reluctant to relinquish. Perhaps these children are receiving more concern and attention in their distinctive status as nonreaders than they would were they to become part of the "undistinguished" reading populace. One such child — a clinic-wise ten-year-old boy—was brought for diagnostic reading tests, after having had a succession of reading tutors. He gazed challengingly at the examiner and stated complacently, "None of the others could teach me. What's your pitch?"

One final consideration in the correction of reading problems involves the provision of sufficient motivation or desire to read. In a culture which provides so many competing media, reading materials must have intrinsic interest for the child. Years ago one basic reader constituted the complete reading program of most schools. "The New England Primer," which in its day was advertised as the book which "taught millions to read and not one to sin," and the McGuffey readers provided the almost exclusive reading materials for children of those years. Today in a culture of space patrols and supermen, reading materials need to include an infinite variety of stimulating information.

The basic concerns in the treatment of reading difficulties, then, are the recognition of individual differences and adapting instruction to the child's abilities. Early identification of those children manifesting extreme difficulty in learning to read and a properly implemented program could serve as the most effective deterrent to reading disabilities in children.

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Summary

DR. JAMPOLSKY: In summarizing the views of the panel members certain common denominators stand out. The problem is not a new one, but rather an old one with poor public education and little progress over a period of years. The actual increase in numbers of poor readers, real or apparent, is difficult to establish, although it is agreed that it is probably real. It appears that the demands are greater today, that a higher value is placed upon reading skills, that reading skill is more necessary in the learning process and in society, and that failure to read well is now more apparent than once it was, since more students remain in school longer now.

Parents sometimes expect as a goal that their child will always be above the average. The problem of the poor reader at times becomes a problem of the parent.

It has been noted that there are different kinds of reading disabilities. There is a small group of poor readers with so-called specific disability with certain established characteristics, and perhaps for this group there is a more specific management. The larger number of poor readers form a complex group and may be characterized by a slow rate of reading, low comprehension, or slowness to learn. The reading disability may be a part of a learning disability. Since there are different kinds of poor readers it follows that there are different causes and different treatment.

The panel members are unanimous that there are multiple causes and contributing factors. Retarded readers may develop a complex picture making it unwise to treat a reading disability without proper knowledge of other obstacles. There are no pat solutions. There is no one method of prevention or treatment.

"Reading readiness" has been mentioned by more than one of the panel members. Some children are late in maturing. If one delays the teaching of reading skills for these students, others will become bored and distracted. There must be proper attention to individual differences and there may be an optimal time for the teaching of reading in school. The importance of proper motivation in the teaching of reading skills has been stressed. Both the school and the home environment should be directed toward revealing the importance of reading skills. Sometimes children will learn to read despite the teacher or teaching method and some will fail.

All are agreed that the children must have a method of word attack, some system by which they may learn new and unfamiliar words. Any single method of teaching reading applied to all children will have the result that some children will fail. A good teacher recognizes individual differences and, with multiple tools for the teaching of reading, adapts them to the needs of the children. It is realized that some teachers, like some physicians, have a keener insight than others into such problems. It is not so simple a problem that it can be solved by going back to the teaching methods of 20 years ago.

A good teacher will recognize when the help of trained personnel is needed. How to get this help poses practical problems. Lest it appear that the views expressed are needlessly complex, certain practical recommendations may be made from the degree of knowledge and area of agreements. The panel members hope to simulate Grecian wisdom by bearing not only blossoms, but some fruit. It is recommended that the teacher be able to seek help from school services. The teacher is concerned not only with reading problems but with speech, hearing and others. It is desirable that one central person, preferably with psychological training, be available for evaluation of the particular problem. If the presence of a physical impediment is suspected, the child should be referred to his own physician or his own medical facility for determination of the specialized medical services that may be needed. After proper evaluation and diagnosis, proper treatment may be instituted. Early diagnosis is important lest needless complications arise.

It will be noted that the ophthalmologist does not believe that the poor reader is primarily an ophthalmological problem. Only occasionally are specific problems found to be the cause of the reading disability. Ophthalmologists are aware of patients seeking ophthalmological care because of missed diagnosis of the reading problem, and while placing due value on visual efficiency, should not overrate it. Children with 20/400 vision may learn to read if they possess a 20/20 brain. But 20/20 vision in the presence of a 20/400 brain may lead to obvious problems. Cerebral astigmatism appears to be more important than the ocular variety.

The panel members recognize that the availability of specialized services of even a central figure with whom the teacher may consult may present practical difficulties. The solution may differ for rural and urban areas because of problems of finance and personnel. Ideals must be compromised with practicability.

The goal is to make it easier for all children to learn to read and to remove all possible obstacles as long as it is practical to do so; and thus avoid the pitfalls that make such panel discussions as this necessary.

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The Electrocardiogram in Primary Coccidioidomycosis

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• Because in some cases of primary pulmonary coccidioidomycosis the principal complaint is pain in the chest resembling that of angina pectoris or coronary occlusion, the electrocardiograms of 20 cases of primary pulmonary coccidioidomycosis were studied, early in the illness and after recovery. In fifteen cases, no electrocardiographic abnormalities were noted. In five cases, findings during the acute illness differed from those after recovery. The changes noted were inversion of T waves and low voltages during the illness, reverting to upright T waves and normal amplitudes after recovery. In none of the cases studied were abnormalities found which might be confused with the electrocardiographic findings in angina pectoris or coronary artery occlusion.

IN MANY CASES pain in the chest is the principal complaint of patients with primary pulmonary coccidioidomycosis. Occasionally the pain is of pleuritic type, but frequently it is not definitely correlated with respiration, and in such latter cases it is sometimes mistaken for the pain of angina pectoris or that of coronary artery occlusion. The present study was undertaken after two patients who, owing to a history of chest pain on exertion, were thought to have angina pectoris, later developed the clinical and laboratory signs of primary pulmonary coccidioidomycosis. The electrocardiograms of patients having proved cases of primary pulmonary coccidioidomycosis were studied to determine whether changes occurred in them during the acute phase of the illness, and, if so, whether the changes were such that they might be confused with those due to heart disease.

REVIEW OF RELATED STUDIES

It has been known for many years that acute infectious diseases produce electrocardiographic abnormalities which usually abate when the patients recover from the diseases. Causes of these changes are myocarditis, fever, peripheral circulatory insufficiency, anemia, anoxia, poor nutrition, electrolyte imbalance, mediastinal shift and pericarditis. Such effects of common infectious diseases on the cardiovascular system have been well reviewed by Fine.[3] Because of the proximity of the heart to the site of the pathological process, cardiologists have been especially interested in pulmonary diseases; and of these diseases the most thoroughly studied has been pulmonary tuberculosis. Bjorkman[1] studied the standard limb leads in large groups of tuberculous and nontuberculous patients and noted that the tuberculous patients had slightly lower P and T waves in leads I and II than did the control group. Fox, Berger, and Meidt[4] studied the abnormal electrocardiograms of 100 patients with pulmonary tuberculosis. Of these, only four were considered to be abnormal due to myocardial damage, and the remaining 96 had changes which the authors felt were due to rotation of the heart and mediastinal shift as a result of the pulmonary pathological changes. ST segment deviations from the isoelectric line in all unipolar leads, inverted P and T waves in AVL, and T wave changes in the precordial leads were all attributed to displacement or rotation of the heart more frequently than to myocarditis. The investigators made a plea for caution in attributing changes of that kind in patients with pulmonary diseases to cardiac origin.

So far as could be determined no previous study has been made of the electrocardiogram in primary pulmonary coccidioidomycosis. Larson and Scherb[5] reported three cases of coccidioidal pericarditis, in one of which the electrocardiographic findings were typical of pericarditis, in one compatible with the diagnosis, and in one nonspecific. The abnormality noted was primarily elevation of the ST segment. In several studies[2, 6] of disseminated coccidioidomycosis attention was given to the myocardial lesions.

METHOD

Twenty unselected patients with early primary pulmonary coccidioidomycosis were studied. They were observed in private practice or in the outpatient clinic of the Tulare County General Hospital. The patients were judged to have coccidioidomycosis if erythema nodosum developed shortly

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Submitted December 28, 1954.

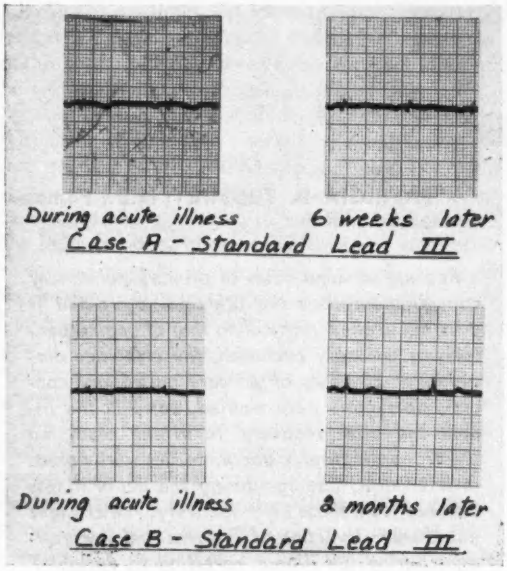

Figure 1.—(Upper charts) Case A, Standard Lead III: *Left*, during acute illness; *right*, six weeks later. (Lower charts) Case B, Standard Lead III: *Left*, during acute illness; *right*, two months later.

after the onset of the illness or if the results of precipitin and complement fixation tests were characteristic of the disease. Serologic studies were carried out in all cases. In several cases of mild infection, erythema nodosum was present but antibodies did not develop. Experience has shown that in an area of such high endemic incidence as the southern San Joaquin Valley, erythema nodosum may safely be considered to be due to coccidioidomycosis when the clinical findings are compatible with this diagnosis.

An electrocardiogram, including the unipolar limb leads and six chest leads, was obtained on each patient on the first visit if primary pulmonary coccidioidomycosis was suspected. If the disease was subsequently proved to be present, a second electrocardiogram was obtained after recovery had occurred. The patient was considered to be recovered after the results of serologic tests and x-ray films of the chest were negative, the sedimentation rate and the temperature normal, erythema nodosum gone, and the patient asymptomatic. Patients in whom disseminated or progressive coccidioidomycosis developed were not included in the study.

Treatment for the disease consisted of bed rest until the fever disappeared and use of acetylsalicylic acid for relief of headache and joint pains. After the febrile period, the patients were advised to rest and refrain from work until the sedimentation rate became normal, but not all complied.

The series was made up of nine male and eleven female patients between the ages of four and 45 years. Seven of the patients were of Mexican ancestry, one was an American Indian, one a Negro and the remainder of native white stock. Most of the adults were agricultural workers who were exposed to dust.

RESULTS AND DISCUSSION

The electrocardiogram remained essentially normal in 15 of the cases, and in five there were significant changes. The types of changes occurring after the patient had recovered from the acute phase of illness were:

1. Previously inverted, flat or diphasic T waves became upright. This change (illustrated in Figure 1, Cases A and B) was noted in four cases.

2. Low voltages increased in amplitude in two cases (see Figure 1, Case B).

In one case, both of the changes were noted.

The presence of electrocardiographic abnormalities did not seem to be correlated with severity of illness, age, sex or racial origin. It was not possible to determine whether the changes were due to cardiac or to extracardiac causes. However, it does not seem likely that they were due to factors unconnected with the illness.

The series of cases is not large enough to warrant statistical treatment of the results or detailed measurements of the components of the electrocardiogram. In general, however, the observations demonstrated that in primary pulmonary coccidioidomycosis, the electrocardiogram will show either no noteworthy changes or changes that are not similar to those of a myocardial infarction or acute pericarditis. The abnormalities that occur after an exercise test in patients having the anginal syndrome are not duplicated in primary coccidioidomycosis. Therefore the electrocardiogram may be useful in differentiating these disease entities in some cases in which pain in the chest is the chief complaint.

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CASE REPORTS

Chondromatous Hamartoma Treated by Transpleural Bronchotomy

Report of a Case with Review of the Literature

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TRANSPLEURAL BRONCHOTOMY was first successfully used for removal of a foreign body in 1904[10] and there is record of ten other cases since that time in which the operation was successfully carried out for that purpose.[4, 5, 11, 18-20]

The same operation was first used for removal of an endobronchial tumor in 1932 by Bigger.[1] Since then it has been used in at least seven patients (Table 1)[2, 7-9, 12, 13] excluding transpleural trachectomy and tracheoplasty operations, which are becoming increasingly common.

REPORT OF A CASE

The following is a report of a patient with a pedunculated endobronchial chondromatous hamartoma treated by bronchotomy:

A 48-year-old man employed as a band saw operator was admitted to the Chula Vista Hospital February 5, 1952, with complaint of cough productive of yellowish sputum streaked with blood, chills and fever of two weeks' duration, shortness of breath and wheeze in the left side of the chest progressive over a period of two years. He had been a heavy smoker for 30 years, had had a chronic cough and pneumonia as a child and had lived in an area in which coccidioidomycosis is endemic.

On physical examination the patient appeared to be acutely ill. Slight cyanosis was noted. The temperature was 101° F. Breath sounds were diminished over the left side of the chest both anteriorly and posteriorly and wheezes and rhonchi were heard bilaterally. Slight clubbing of the fingers was also noted.

An x-ray film of the chest on the day of admittance (Figure 1) showed infiltration in the lingula and anterior segment of the left upper lobe. It was almost completely subsided five days later.

The patient was treated with streptomycin and aureomycin and was discharged February 18, 1952, afebrile but with little change in auscultatory abnormalities in the chest. The diagnosis was primary atypical pneumonia.

Five days later the patient was readmitted with recurrence of former symptoms and of roentgenographic abnormalities in the chest. After therapy with aureomycin he was discharged as improved, with x-ray changes again partially subsided, on March 9, 1952.

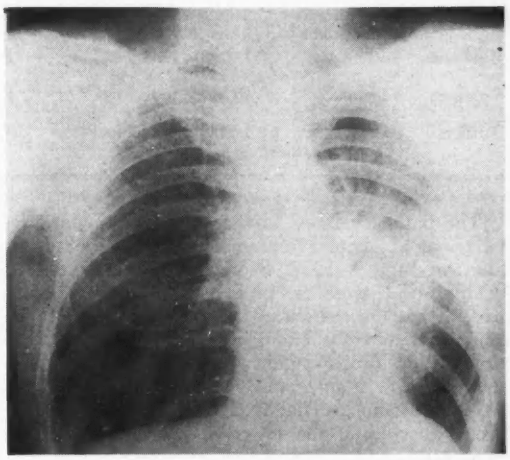

Figure 1.—Preoperative film taken February 5, 1952.

He was admitted a third time on March 14 because of recurrent symptoms. Upon bronchoscopic examination "an overgrowth of epithelium measuring almost a centimeter in greatest diameter, partially occluding both upper and lower lobe orifices, and free of ulceration," was found. Several biopsy specimens were taken from this mass, as well as secretions for cell block study. The bronchoscopic impression was: "Probable carcinoma involving juncture of left upper and lower lobe bronchi." The biopsy was reported showing "mucosa composed of well differentiated epithelial cells, the underlying submucosa showing a mild diffuse lymphocytic and plasmacytic infiltration." There was no evidence of malignant change in the biopsy specimens or in the cell block of secretions. In view of the long history of wheezing, shortness of breath and expectoration, the patient was considered a poor risk for pneumonectomy, and laminagrams of the left hilum for better visualization of that area were suggested. The patient refused the additional roentgen studies, however, and was discharged March 24 with a diagnosis of suspected left bronchogenic carcinoma, pulmonary emphysema and probable bilateral bronchiectasis.

TABLE 1.—*Bronchotomy for tumors*

Reported by	Tumor	Location	Sex and Age	Bronchoscopy	Date of Bronchotomy	Result
Bigger	Carcinoma basal cell	Lt. main bronchus	M 14	Narrowing, no biopsy	3-1-32	Died 3 days after secondary pneumonectomy
Eloesser	Carcinoma relatively benign	Lt. lower lobe bronchus	F 33	No tumor visible	10-2-39	Well 7 months later
Goldman	Adenoma	Lt. main bronchus, intramural, no pedicle	F 31	Removal 7 years prior to bronchotomy	3-8-46	Well 3 months later
Langston and Fox	Fibroma	Lt. main bronchus, pedicle dorsal branch bronchus	M 26	Biopsy	12-24-46	Well
Goldman	Adenoma with metastases	Trachea and left main bronchus	M 58	Removal over 6-year period	1947	Died of metastases 2 months postoperatively
Brown	Granular cell myoblastoma	Mouth of lt. bronchus, lower lobe	M 48	Lobulated mass	12-6-48	Well 9 months later
Goldman	Adenoma	Lt. main bronchus	F 14	Biopsy	1949	Living and well 2 years postoperatively
Goldman	Adenoma	Rt. main bronchus	F 45	Five-years before with removal of tumor	1949	Living and well 18 months postoperatively
Authors	Hamartoma (Chondromatous)	Lt. main bronchus	M 49	With biopsy twice; diagnosis not made till surgery	6-24-52	Well 24 months later

The patient refused further observation until recurrence of acute symptoms necessitated readmission on June 9, 1952. Bronchoscopic observations at that time were essentially the same as before except that the mass seen previously seemed to be somewhat movable and a pedunculated tumor was thought of. Biopsy again was negative for malignant disease. Planigrams on June 17 showed "an ovoid mass measuring 3 x 0.5 cm. almost completely occluding the lower end of the left main bronchus."

On June 24 operation was carried out. With the patient face down, the left pleural cavity was entered through the fifth intercostal space. The posterior aspect of the lung root was freed, several branches of the vagus nerve being divided and the pulmonary artery encircled by a Penrose drain for traction. The main bronchus was then isolated and a Penrose drain was passed around it. A hard movable tumor mass was palpated in the main stem bronchus and the membranous portion opened longitudinally for a distance of 2.5 cm. The smooth resilient, slightly lobulated tumor mass was readily visualized and grasped with a curved clamp and drawn through the bronchotomy incision. It was attached by means of a narrow pedicle 1 cm. in length to the juncture of the upper and lower lobe bronchi on the anterior aspect of the carina. The pedicle was clamped with a small curved hemostat at its juncture with the carina and amputated. The stump of the pedicle was cauterized with a silver nitrate stick and the incision closed with interrupted 0000 silk sutures in one layer. A pleural covering was approximated over the incision and the wall of the chest was closed by means of catgut pericostal sutures and interrupted silk, two intercostal catheters attached to water trap bottles being inserted prior to closure. The patient withstood the procedure well.

Postoperatively the patient did well and noted that he was able to "breathe better than in many months." The intercostal tubes were removed on the third postoperative day and the patient was discharged on July 11 with good breath sounds bilaterally and films of the chest showing only postoperative pleural reaction. Upon examination a year and a half later the patient was well and said he had been well in the interim (see Figure 3).

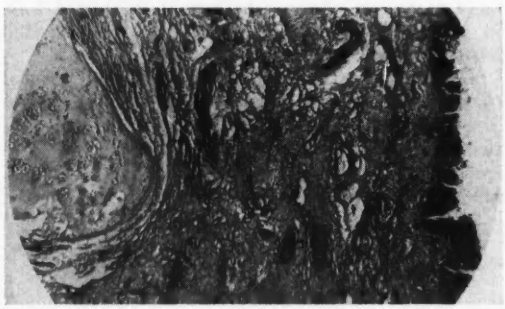

Figure 2.—Photomicrograph of section of excised tumor.

PATHOLOGIST'S REPORT

The tumor was described as follows: "The specimen was a tumor 12 x 14 mm., having a smooth surface covered by mucous membrane. There was a pedicle a few millimeters in length protruding from one area of the tumor. A mid-section showed a mass of shiny white nodules, ranging from 6 x 2 mm. to 1 x 3 mm. in diameter, with a dark fibrous tissue surrounding them. Microscopically (Figure 2) the growth was observed to be covered by a dark-staining pseudostratified epithelium. The nodules were hyaline cartilage, with flattened cells in most of the periphery. The connective tissue was quite vascular and, in general, cellular with scattered lymphocytes and plasma cells. Some vessels had round cell collars and a few fat cells were present. The varied cell types of normally found elements, with cartilage predominating, made the diagnosis chondromatous hamartoma."

TABLE 2.*—*Intrabronchial chondromatous hamartomas*

Reported by	Year	Age and Sex	Bronchoscopy	Site	Treatment
Chiari	1883	68 F	.....	Right	.....
Siegert	1892	61 F	.....	Left	.....
Spuler	1902	? ?	.....	Left	.....
Eicken	1907	41 F	Visualized	Left	Excision via bronchoscope
Blecher	1910	21 M	.....	Left	.....
Spiess	1910	47 F	Visualized	Right	Excision via bronchoscope
Caussade, Surmont and Lacapere	1925	53 M	.....	Right	.....
Paul	1930	69 M	.....	Left	.....
Moore	1932	68 M	.....	Right	.....
Gebauer	1938	44 M	Visualized	Right	Excision via bronchoscope
Davidson	1941	66 M	Visualized	Right	Excision via bronchoscope
Ulrich	1941	57 M	Visualized	Right	Excision via bronchoscope
Postlethwait, Hagerty and Trent	1948	57 M	Visualized	Left	Lobectomy
Carlson and Kaier	1950	59 M	Visualized	Left	Bronchotomy
Effler and Scheid	1951	56 M	Visualized	Left	Pneumonectomy
Rubin and Berkman	1952	68 M	.....	Right	.....
Moersch, Donoghue and McDonald	1952	50 F	Visualized	Right	Lobectomy
Ibid		46 M	Visualized	Left	Excision via bronchoscope
Ibid		61 F	Visualized	Right	Excision via bronchoscope
Chambers and Averill		49 M	Visualized	Left	Bronchotomy

* Modified from Postlethwait and co-workers.[16]

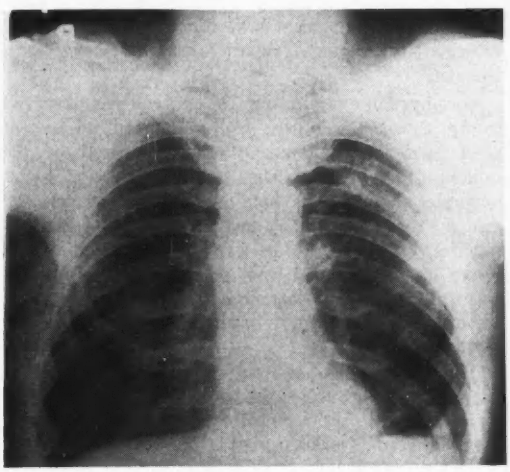

Figure 3.—Film of chest a year and a half after operation.

DISCUSSION

About 100 cases of hamartoma of the lung had been reported by 1945, when McDonald, Harrington and Clagett[14] reviewed this condition. Not included in their report were endobronchial tumors of similar appearance. In 1948, Postlethwait and coworkers[16] reported twelve such endobronchial cases and added a report of a case they had observed. Since then six additional cases of endobronchial hamartoma have been reported.[3, 6, 15, 17] The data on the 19 cases are summarized in Table 2.

The symptoms, in the cases in which symptoms were reported, were those of bronchial obstruction with distal suppuration. In order of frequency the symptoms were: cough, purulent sputum, dyspnea, hemoptysis and wheeze. The diagnosis was made at autopsy in eight cases, by bronchoscopic examination in eight and presumably at operation in three cases.

The term *hamartoma* has been used to apply to growths in which an abnormal distribution of normally found components is present. Since the predominant tissue in these tumors is cartilage, the term *chondromatous hamartoma* seems appropriate, although *chondroma* was used in the early references.

No definitive treatment was used in eight patients. Excision through a bronchoscope was used in seven patients with recovery in each case. Pulmonary resection was done in three patients—one pneumonectomy and two lobectomies—with recovery. In one patient,[3] the finding of a chondrohamartoma was incidental in that bronchoscopic examination for carcinoma of the right bronchus was performed and the benign tumor was observed in the left main stem bronchus. The only mention of the treatment in this case was in a table in the article which stated, "Bronchotomy with excision of hamartoma. The patient died with an inoperable carcinoma of the right lung." With this exception the case reported herein is unique in the treatment of the disease.

SUMMARY

A case of pedunculated endobronchial chondromatous hamartoma is reported. Treatment consisted of transpleural bronchotomy and excision of the tumor. A review of the literature on bronchotomy and hamartomas is presented.

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Pseudoxanthoma Elasticum with Gastrointestinal Bleeding

RICHARD P. REINERTSON, *M.D.*, and EUGENE M. FARBER, *M.D.*, San Francisco

PSEUDOXANTHOMA ELASTICUM is a disease of elastic tissue involving the skin, Bruch's elastic membrane of the eye, and the arteries. It was named by a dermatologist, Darier,[3] in 1896 because of the superficial resemblance of the lesions to xanthomata, and because the elastic tissue of the cutis in this disease is clumped and frayed.

Recently a patient was observed on the medical ward at Stanford Hospital with pseudoxanthoma elasticum associated with intestinal bleeding.

CASE REPORT

The patient, a 17-year-old white American school girl, was well until the age of ten years, when she became pale and easily fatigued. A physician then found that she had pronounced anemia. She was given a transfusion of whole blood at that time, as well as liver and iron therapy. She felt well until, at the age of 13, she had several tarry stools over a period of one month. After profuse hematemesis, one unit of blood was infused and the patient was referred to Stanford Hospital on February 8, 1951.

The parents and two younger siblings were alive and well, had no skin disease and no hemorrhagic complaint or other chronic disorders. One sibling was stillborn; another died at the age of three months of "choking" (no more is known about the cause of death).

The patient had had measles at the age of five years and a simple fracture of the right radius when she was nine. She had worn glasses since the age of seven, and when she was nine years of age had a successful surgical repair of right lateral strabismus.

On physical examination the patient was observed to be a well-developed, well-nourished adolescent with moderate paleness of the skin and of the mucous membranes. She had microcytic, hypochromic anemia. The hemoglobin content was 7.0 gm. per cc. of blood. A test of the stool was positive for occult blood. In x-ray examination of the upper gastrointestinal tract no definite abnormality was noted but there was suggestion that there might be an intramural tumor of the third portion of the duodenum.

The patient reentered the hospital 18 days later. A transfusion of two units of blood was given, and on March 3, 1951, exploratory laparotomy was performed. There were no visible abnormalities of the abdominal or pelvic viscera. The transverse duodenum was opened and there were no palpable or visible defects of the mucosa. The appendix and a liver biopsy were microscopically normal. The patient was discharged without diagnosis.

There was no further gross bleeding for almost a year, but the patient entered Stanford Hospital for the third time on February 2, 1952, after vomiting two cups of bright red blood and passing a tarry stool. An intern observed "irregular areas of depigmentation over both arms and shoulders." Several clotting studies were done: platelets numbered 330,000 per cubic mm.; coagulation time (Lee-White) was 8 minutes, 30 seconds; the result of a Rumpel-Leede test for capillary fragility was negative. Bleeding time by the Duke method was 5 minutes, 30 seconds; this was apparently not judged abnormal at the time and was not repeated. Gastrointestinal examination by x-ray showed a normal duodenum, with some question this time about the esophagus. Esophagoscopic and gastroscopic examinations were done and no abnormalities

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Submitted March 8, 1955.

were observed. A transfusion of one unit of blood was given and the patient was discharged again without diagnosis.

Six months later a bout of hematemesis was treated by a physician outside the hospital. The patient was fairly well throughout 1953, but from May until August, 1954, she became increasingly anemic as the result of several episodes of hematemesis and melena. At times the sputum was blood-streaked but the question of whether the bleeding was gastrointestinal or from the respiratory tract was not fully decided. The patient continued to grow anemic despite four transfusions and she entered Stanford Hospital for the fourth time on August 17, 1954.

It was observed on the medical service that a peculiar change had taken place in the texture of the skin of the neck and axillae, and a dermatological consultation was requested. At this time the patient said that the lesions had been present ever since the first bout of hematemesis at the age of 13.

On examination of the skin, bilaterally symmetrical lesions limited to the neck, axillary folds, and antecubital spaces were noted. The lesions consisted of rows of flat-topped papules 1 to 2 mm. in diameter, the color of normal skin, arranged along natural lines of skin folds. The skin felt rough and was rather loose and easily stretched. The fundi were examined and typical angioid streaks about the discs were noted. Although the patient continued to complain of easy fatigability and aching in the legs after exertion, there was no significant diminution in pedal pulses, nor was calcification of the vessels of the legs observed on x-ray examination.

The clinical diagnosis of pseudoxanthoma elasticum was confirmed by biopsy of a specimen of skin. Elastic Van Gieson stain showed clumped, thickened, broken and frayed elastic tissue throughout the entire cutis, more in the midcutis. The Von Kossa stain for calcium showed a heavy deposit of calcium in the region of altered elastic tissue.

Again, the site of bleeding was not determined. No abnormalities were noted in x-ray studies of the chest, in a bronchogram or at bronchoscopic examination. Roentgen studies of the gastrointestinal tract were again not helpful. A bland diet was prescribed and the patient was discharged in the care of a private physician.

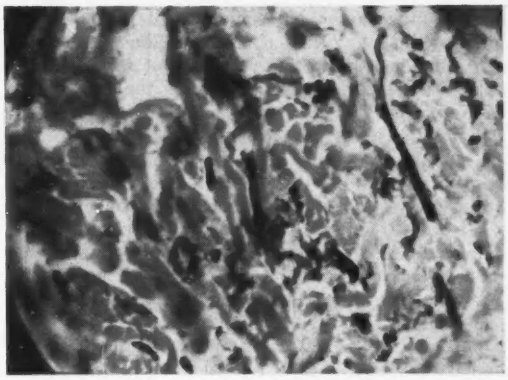

Figure 1.—Midcutis. Elastic Van Gieson stain (×440). Pseudoxanthoma elasticum. The dark-staining elastic tissue is thickened, clumped, frayed, and broken.

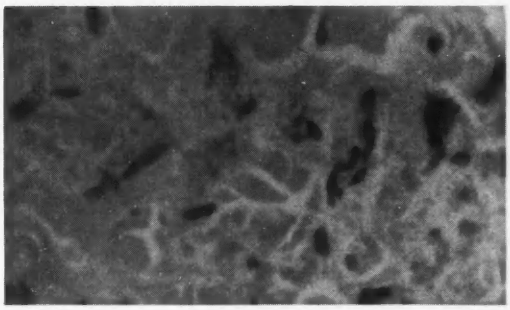

Figure 2.—Midcutis. Von Kossa stain (×440). Pseudoxanthoma elasticum. Dark-staining calcium is deposited within degenerated elastic tissue.

DISCUSSION

Pseudoxanthoma elasticum is an uncommon disease. Since it was first described by Balzer[1] in 1884, fewer than 200 cases have been reported. The pathological changes were considered to be limited to the skin until 1929, when Gronblad[5] and Strandberg[8] separately observed the association of pseudoxanthoma with angioid streaks of the fundus. The most widely accepted theory of the cause of angioid streaks is that they are due to degeneration of Bruch's elastic membrane of the choroid.[4] In 1938, autopsy material was presented to show that in pseudoxanthoma there may be widespread degeneration of elastic tissue in any of the larger arteries,[7, 10] and in 1944 Carlborg[2] reported that patients with this disease have a high incidence of demonstrably diminished peripheral arterial pulsation and calcified peripheral vessels. These changes were attributed to degeneration of elastic tissue and altered pulse waves rather than to obstruction of arterial lumena. An increased familial incidence has been observed. Revell and Carey recently reviewed the autopsy observations and the literature.[9]

Eight cases have been reported in which gastrointestinal bleeding was associated with pseudoxanthoma. There are reports of autopsy material in three of these.

Prick[7] reported the case of a 48-year-old woman with skin lesions and angioid streaks who died following hematemesis and cerebral hemorrhage. Tortuous and thickened vessels causing impressions into the jejunum and ileum were noted at autopsy. The vessels contained considerable degenerated elastic tissue.

A case reported by Law,[6] that of a 17-year-old boy with skin lesions and angioid streaks, hematemesis occurred repeatedly. At laparotomy, the

gastric mucosa showed "evidence of recent hemorrhages with many dilated vessels in the submucosa." An acute gastric ulcer was noted, and gastrojejunostomy was performed. A month later the patient died and at autopsy a "leak on the anterior aspect of the proximal gastrojejunal junction" was noted.

Carlborg[2] reported autopsy observations in the case of a patient with skin lesions and angioid streaks who died following hematemesis at a hospital where pseudoxanthoma was not recognized. The pathologist's report included pulmonary tuberculosis and cirrhosis of the liver with esophageal varices. No elastic tissue stains were done.

Revell and Carey,[9] and Wolff and co-workers[11] reported three recent cases, the patients varying in age from 9 to 29 years, in which repeated bouts of gastrointestinal bleeding were treated successfully with transfusions.

SUMMARY

A case of gastrointestinal bleeding, presumably due to pseudoxanthoma elasticum, is reported. The patient had had chronic and acute loss of blood from the gastrointestinal tract from the age of 10 years until the age of 17 years, when the diagnosis was made. A brief review of other cases of gastrointestinal bleeding in pseudoxanthoma elasticum is presented.

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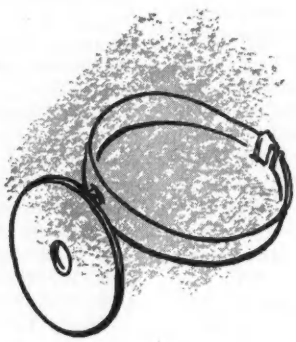

California MEDICINE

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EDITORIAL

Back-Door Socialization

IF ANY PHYSICIAN thinks that the social planners have given up their attempts to socialize medicine, he should take heed of the current attempt to force through the Congress a long series of amendments to the Social Security Act. Now labeled HR 7225, this set of amendments very slyly opens the door to socialized medicine and virtually begs for further amendments and additions which would make that goal come constantly closer.

Progress of this measure through the committees of Congress and on the floor of the House of Representatives shows that the socializing forces in Washington have not only a large reserve of power but the political acumen to put that power to work.

HR 7225 is the brain child of Representative Jere Cooper, Tennessee Democrat who is chairman of the House Ways and Means Committee. Typical of the power he has shown in promoting this amendment to the Social Security Act is the fact that his own committee reported the bill out favorably before the measure had even been introduced or given an official number.

To detail the various amendments included in HR 7225 would require a large volume. Suffice it to say that the principal interests of physicians in the bill lie in two parts. First is in the inclusion under the Social Security Act of self-employed persons in the fields of, among others, dentistry, law, optometry and veterinary medicine. Second is the establishment in the law of a brand new program of payments from the Social Security Fund of benefits to compensate for total and permanent disability.

On the first of these two points, medicine has made itself heard. Physicians have *not* been included in the list of self-employed persons who would, if this measure passed, be required, willy-nilly, to contribute to the Social Security Fund. For this exclusion, credit must go to a few individuals who have steadfastly fought for recognition of personal retirement programs which could be built upon income tax deductions during the earning years and income tax payments on future benefits when earning capacity declines.

As to the matter of payment of benefits for total and permanent disability, medicine has every reason to fear in it the inauguration of a system of socialized medicine. If such payments are to be made, the applicants will certainly require medical certification of disability. Enter the physician. Also, enter the chiropractor, faith healer and others already recognized by those few state governments which have thus far experimented with payments of this character.

Once the physician is in the act, in the role of a certifying agent, he comes under the regulations and proscriptions which government always sets up under its programs. When he becomes accustomed to that regime, why not add a few more duties in the way of therapy? Legislation which can be rammed through one-half of our Congress in the manner this bill has progressed offers every inducement for added governmental invasion into the field of private initiative.

As an example of governmental medicine, one section of HR 7225 requires that beneficiaries of the total and permanent disability program must submit themselves to rehabilitation. Who will supply the care under that requirement? Who will name the conditions, fees, and other stipulations of a nationwide rehabilitation program? A glance at our present rehabilitation and crippled children's programs will give the answer: the physicians have no part to play except to provide the medical service needed, under terms and conditions laid down by the social planners.

The political acumen referred to above is amply demonstrated in the methods used by the author of

the bill to shove it through the Congress. The bill in dream form was passed out of the Ways and Means Committee even before it had been drafted or numbered. The vote was strictly on party lines. Moved into the Rules Committee, by which time it had been given a number, HR 7225 was again passed out favorably, again on a party line vote. Meanwhile, *no public hearings were held.* No expert advice was asked. No proponents or opponents outside the two communities had a chance to be heard. No actuarial advice was sought; no financial advice.

These two committees handed the House of Representatives a new measure which will cost an estimated two billion dollars annually. Of course, the money comes from the taxpayers in the form of higher social security taxes for both employer and employee. When and if further medical therapy is added, these taxes will again go up.

On the floor of the House of Representatives, HR 7225, under a suspension of the rules, was limited to 40 minutes' debate. This is popularly known as the "gag rule." On a two billion dollar measure, affecting millions of people, after only 40 minutes of debate, the bill was passed by a vote of 372 to 31. The strategy here was to put every Congressman in the spot where, with elections coming up in 1956, he would be too embarrassed to vote against a new extension of the give-away program. It even appears that this same strategy may have pervaded the White House, where it might give pause to a veto when and if the bill goes through the Senate.

At this writing there seems some hope that the Senate will not act favorably on HR 7225 during this session of Congress. But just wait for the next session. Back will come HR 7225, with a few new clauses and a new number. Will the Senate still have the courage to step in and stop this further incursion into our personal lives and fortunes? Or will the proponents of this legislation have gathered enough added strength to push their bill through both houses of Congress?

The medical profession will do well to keep a watchful eye on this back-door approach to socialized medicine. It is obvious that the planners for tomorrow are still at work and as full of cunning as ever.

LETTERS to the Editor . . .

Chronic Prostatitis

THIS IS A LETTER to the Editor if such a forum exists. The article published in June, 1955, of CALIFORNIA MEDICINE entitled "Chronic Prostatitis: A Psychosexual Approach," by David Rosenbloom, M.D., is in my opinion so misleading that I cannot refrain from taking issue with the ideas that are expressed. At the outset I will admit that part of the problem is one of semantics since the misconceptions which are fostered in this article are often the result of terminology and furthermore I agree with many of the observations which the author made regarding symptomatology and objective findings in the group of patients he was talking about. The real trouble lies in the label which he applied to this group of cases.

In the first place Dr. Rosenbloom was not really talking about chronic prostatitis at all, as the term is generally understood by urologists. If he had used the word which he coined, "prostatosis," instead of the term *prostatitis*, he might not be challenged. The group of symptoms which he described as "a discharge of thin, mucoid material from the urethral meatus, worse upon arising . . ." which "often stains the underclothing . . . seems to come and go without definite causal relationship to daily events" . . . often is "associated with mild dysuria, terminal dysuria, a feeling of incomplete urinary emptying" and discomfort in the perineum, low lumbar area, sacral area and sometimes in the testes and urethra—that group is certainly a commonly observed syndrome even in northern California, but to label this *chronic prostatitis* is completely improper and is misleading to those in general practice or other specialties who do not see it often enough to differentiate it from true prostatitis by the very simple methods which are at hand. I am sure that most urologists also agree that this is a psychosexual disturbance. No issue is taken with the author on the method of handling this type of case. Let's talk about prostatitis, however, because that is what the author labeled his article, and that is what most readers might think he is talking about.

Chronic prostatitis is a real, clear-cut, clinical entity, simple to diagnose when the proper methods are applied but obscure as to etiology and the treatment of which is frequently unsatisfactory and prolonged. That the treatment is not entirely satisfactory in many cases and has made little or no progress in an era when great progress has been made in other medical conditions, is no reason to place the diagnosis in obscurity, in my opinion.

The condition is observed sometimes in the late teens but more commonly in the 20's, 30's and 40's and somewhat less commonly in the older age groups. Various complaints may bring the patient to the doctor. The patient commonly complains of fatigue without much else to go with it. This he frequently terms "lack of pep," loss of his usual ambition both at work and play, sometimes a moderate loss of libido, frequently a mild low backache in the sacral area which is worse in the morning upon arising and improves after some physical activity and moving about in the morning. This type of individual will have completely negative physical findings and the urine is also usually completely negative. Unless the doctor is thinking of prostatitis as a possibility he will miss the opportunity to make the diagnosis at this stage. The prostate is ordinarily not remarkable to palpation and it is only upon purposeful milking of the prostatic secretion and examination under the microscope that the diagnosis of prostatitis can be made. About half of the group will have some associated urinary symptoms which are in the nature of frequency, urgency and dysuria.

Patients with such symptoms usually are seen by urologists and the two-glass urine test will show a significant number of pus cells in the first glass with definitely less or none at all in the second glass of urine. Here the clue is obvious and a prostatic massage with the obtaining of the prostatic secretion for examination is all that is needed to make the diagnosis.

In my experience fewer than 25 per cent will have noticed any urethral discharge in association with the above symptoms. Cases in which there is urethral discharge are not necessarily cases of chronic prostatitis; they may be owing to psychosexual disturbance. The distinction is easily made by the above mentioned methods. A signicant number of patients with chronic prostatitis whose symptomatology is outlined here, will not show more than an occasional pus cell in the prostatic secretion in the first specimen obtained by massage. Sometimes even the second specimen three or four days later will have few pus cells, but the third massage will usually produce the typical flood of many pus cells in the prostatic secretion. The lesson here is that if the story is very typical, one should persist in several diagnostic massages until prostatitis has been definitely ruled out.

Acute prostatitis is not, as is implied by the author of the article, an entirely different condition; and, contrary to his statement, I believe that acute prostatitis will usually not respond to the antibiotics. My own experience, over a period of about the same length of time that the author mentions, is that in fewer than 20 per cent of cases will there be any real change in the prostatic secretion with any type of antibiotic. Antibiotics should be used, however, because in these cases the bladder, especially the trigone and sometimes the kidney pelves, are involved in the infection and there is associated fever, leukocytosis, increased sedimentation rate and sometimes epididymitis. All of these complications (because that is what they are) of prostatitis will respond to the sulfonamides or the antibiotics quite promptly. What remains after the acute phase is over is chronic prostatitis and that the prostate gland is quite vascular is true from the surgical standpoint, but his intimation that the antibiotics administered by mouth or parenterally infuse the gland in adequate concentration is an unjustified deduction which does not follow the observations of other investigators. In fact, the contrary can be more logically assumed.

The most important point, I think, that should be made about prostatitis, either acute or chronic, is that it is the cause of the overwhelming majority of symptoms in the urinary tract of the male. General practitioners could deal with this large percentage of the urological problems presenting themselves if they would use a step-by-step procedure which includes physical examination of the genitalia, a two-glass urine test and a thorough prostate examination both by palpation and a stripping of the gland to obtain the prostatic secretion for microscopic examination.

Finally, it is perfectly patent that the treatment of prostatitis leaves much to be desired. Prostate massage, done properly, remains the basic treatment. Other procedures such as urethral calibration with sounds to rule out strictures and the treatment of complications with sulfonamides and antibiotics are necessary, but most of the other things such as irrigations and instillations have fallen by the wayside. A significant number of patients who do not respond to the standard methods can be cured by the direct injection of the prostate through the perineum with a spinal-type needle, using such antibiotics as penicillin, neomycin or terramycin.

Despite all the shortcomings of the treatment of prostatitis, I feel that it is quite important not to confuse the profession with articles such as this for the reasons that I have tried to outline above.

ROBERT A. BURNS, M.D.
Woodland Clinic Hospital
650 Third Street, Woodland

Editor, CALIFORNIA MEDICINE:

THANK YOU for your kindness in permitting me to answer Dr. Burns' letter. Careful reading of my paper would demonstrate immediately that the term "prostatosis" was suggested as a substitute for "prostatitis" precisely because of the greater ac-

curacy of the word "prostatosis." The word "prostatitis" is used in the title simply because nearly everyone employs it. This is not a mere semantic differentiation, because my entire concept is based upon the opinion that "chronic prostatitis" is largely not infective in origin. To repeat the summary of the paper, " 'Chronic prostatitis' unaccompanied by signs of active inflammatory disease is a psychosexual disturbance, not a bacteriologic disease. Prostate massage, local therapy, and antibiotic therapy are usually of no therapeutic value; a careful history and evaluation of the background and good social and psychiatric counseling are the only effective and rational means by which this so-called 'prostatitis' is controllable."

Specifically, in answer to some of the details raised by Dr. Burns, the prostate gland is not singularly immune to antibiotic drugs which penetrate all other vascularized tissues. Unless a true abscess is present (which is rare), oral and parenteral antibiotic drugs are present in the prostate gland in adequate concentration. Simultaneously performed penicillin assays on blood and prostate fluid, in a patient receiving penicillin, will demonstrate adequate penicillin levels in the prostate fluid. Prostate fluid leukocytes ordinarily do not diminish in number after antibiotic therapy because usually they are not caused by infection. Bacterial cystitis and pyelonephritis are infections which will respond to correct antibiotic therapy. The concept that "chronic prostatitis" is simply a residuum of acute prostatitis is erroneous.

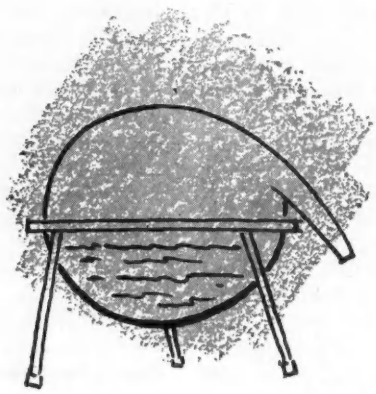
I have not seen a documented series of patients who were "cured" after direct injection of drugs through the perineum into the prostate gland with a long needle. If this must be performed, I would suggest the use of a panendoscope plus the "flexible infiltrating needle," A.C.M.I. catalog No. 193, which should accomplish the same purpose more accurately and elegantly, less dangerously, and with diminished medicolegal hazard.

I do not understand the several contradictions in Dr. Burns' letter. First he states that "the urine is also usually completely negative" and then says that "the two-glass urine test will show a significant number of pus cells in the first glass." It states that one must "persist in several diagnostic massages until prostatitis is definitely ruled out, then a "typical flood of pus cells will be produced after prostate massage every 3 or 4 days" from a prostate gland which "does not show more than an occasional pus cell in the prostate secretion in the first specimen." Which is correct? What is the "obvious clue"? The prostate gland consists of living tissue which becomes edematous and inflamed after injury. Certainly, vigorous prostate massage "every 3 or 4 days" will produce "a typical flood of pus cells." The correct term should be "traumatic prostatitis."

My article was written to clarify and to inform and enlighten; it does not "foster misconceptions," nor does it "mislead" anyone. It is not I who is confused.

DAVID ROSENBLOOM, M.D.

July 15, 1955.



California MEDICAL ASSOCIATION

NOTICES & REPORTS

The A.M.A. President-Elect

NEW HONORS came to California this year when Dr. Dwight Harrison Murray was unanimously elected President-Elect of the American Medical Association.

When he takes office in the summer of next year, Dr. Murray will be only the fifth Californian to become President of the Association in the 108 years since it was founded. The others from this state who have received the rare honor: Thomas Logan of Sacramento, in 1873; R. Beverly Cole, San Francisco, in 1896; Ray Lyman Wilbur, Stanford University, in 1923; and John W. Cline, San Francisco, in 1951.

In personal qualifications and in apprenticeship and long service in medical organization work, Dr. Murray is exceptionally well equipped to continue the tradition of outstanding leadership established by the Californians who have preceded him.

Dr. Murray—"Murph" to his many friends—began by holding office in the Napa County Medical Association not long after he opened general practice in Napa following discharge from the Navy at Mare Island in 1922. His separation from service brought to a close a tour of duty that had begun in 1917 upon his graduation from the University of Indiana Medical School.

He was president of his county medical association, then a delegate to the California Medical Association. He was named chairman of the C.M.A. Committee on Public Policy and Legislation in 1940 just at the beginning of strong political drives for socialization of medicine in California. It was in that capacity that his great talent for honest persuasion came into full use. The very attributes that gave him easy rapport with patients and that made him an outstanding physician in his own community were of great value also in dealing with legislators. Warm, friendly, gentle, understanding and tireless, Dr. Murray came to be looked upon in legislative circles as the epitome of all the qualities they most admired in physicianship. His willingness

DWIGHT H. MURRAY

to listen thoughtfully to expressions of points of view to which he was opposed, and still to advocate his own, served the C.M.A. and later the American Medical Association well. He has been aptly called "a most persuasive listener." Slow and deliberate of speech, he impresses even opponents with the calm of his sureness.

The guiding force behind establishment in 1944 of the United Public Health League, he was instrumental in the opening of medicine's first office for legislative representation in the nation's capital. The office supplied information to members of Congress seeking it in order to be able to take an intelligent position in matters of medical legislation.

This emergence upon the national legislative scene came in the first year after he became a delegate to the A.M.A. Soon afterward his extensive knowledge and cogent abilities in the field of politics as they affected the practice of medicine were given broader recognition in his election to membership on the A.M.A. Board of Trustees. He served as chairman of the Board's legislative committee for several years and then in 1951 became chairman of the Board. In that spiralling progression, Dr. Murray had more and more to do with organizing the American Medical Association along the lines it has followed in the past decade. The constantly increasing number of people who came to know him were soon or late impressed by the vast amount of information that he kept track of—by the store of data he kept at the front of his mind or could find swiftly when it was needed.

The new President-Elect was born on a farm near Springville, Indiana, in 1888. Married in 1921 to Miss Genevieve Collins, he is the father of two children, a daughter, and a son who is at present assistant resident on the surgical service of the University of California Hospital. He has five grandchildren.

Patients and neighbors who know him in his own community as a physician and friend agree with his own description of himself: "Family style doctor." Those who have worked with him in medical organization can add the epithet *good leader.*

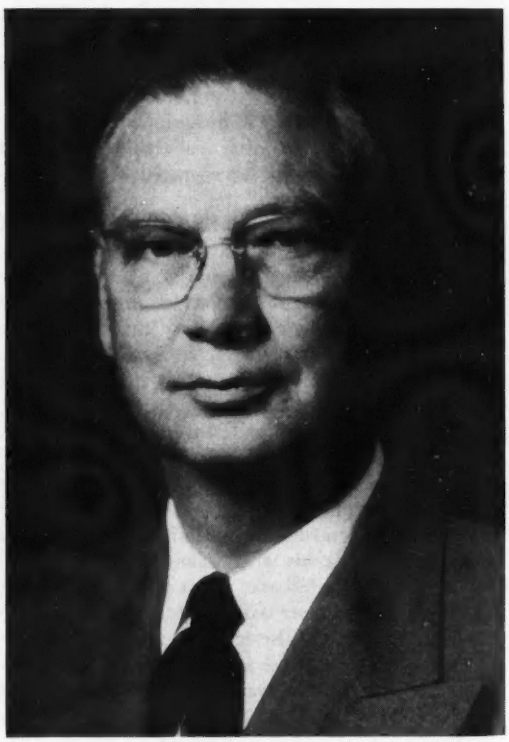
The New Speaker of the American Medical Association

THE NEW SPEAKER of the House of Delegates of the American Medical Association, Dr. E. Vincent Askey, lifts the gavel with a long and comprehensive preparation in the field of medical organization that fits him eminently to succeed to the post held by his many distinguished predecessors.

Dr. Askey was born in Sligo, Pennsylvania. His early and secondary education was obtained in the public schools of Pennsylvania, New York and Washington state. He received the degree of Bachelor of Science from Allegheny College in 1917 and the degree of Doctor of Medicine from the University of Pennsylvania in 1921. Immediately thereafter he entered upon a residency training in surgery. The years 1921-1923 were spent in the Episcopal Hospital of Philadelphia and the year 1923 to 1924 in the Kensington Hospital for Women in the same city.

Early distinguishing himself as an outstanding student, Dr. Askey was elected a member of Alpha Omega Alpha and Alpha Chi Sigma honorary fraternities. He is also a member of Delta Tau Delta and Nu Sigma Nu.

He has practiced his specialty of surgery in Los Angeles since 1924 and has been a member of the Los Angeles County Medical Association continuously during that period. Early evidencing an unusual interest in medical organization affairs, Dr.



E. VINCENT ASKEY

Askey became secretary-treasurer and trustee of the Los Angeles County Medical Association in 1935, a post which he held until 1937, continuing as trustee from the years 1937 to 1942. He became the county association's president in 1942.

Notwithstanding a busy surgical practice and his important contributions to the county medical association, he became a member of the Board of Education of Los Angeles in 1937; he continued in that position through 1943 and was president of the board in 1941.

It was only a natural and appropriate sequence that Dr. Askey should extend the scope of his influence and the benefit of his organizational talents to the state level. He became vice-speaker of the House of Delegates of the California Medical Association in 1943 and held that post until 1945. He was speaker of the House of Delegates from 1945 until 1947. Paralleling these state activities he became a delegate to the American Medical Association in 1944, a post which he still holds.

Dr. Askey's work in the House of Delegates of the California Medical Association and on the Council by virtue of his membership in its official family came during what some future historians will no doubt describe as the darkest days of the profession. Fortunately he was serving at a time when pressure by politicians during the days of World War II for socialization of medicine seemed about to prevail.

As the result of proposals that had been made by Dr. Askey several years previously, a state-wide public relations survey had been made in order to ascertain just what the people thought of California physicians and what they would like to have them do with respect to prepaid medical care. Following a careful study of many phases of this problem, California Physicians' Service was organized in 1939, designed primarily to supply prepaid budget medicine for persons in the lower income groups. With this organization as tangible evidence that the California Medical Association did in fact have an active and a constructive plan based on the voluntary prepayment of the cost of illness, and consequent upon an active and aggressive campaign of informing the people of the real advantages of the voluntary plan as opposed to compulsion, compulsory plans were defeated in 1945 and in subsequent legislative sessions.

Dr. Askey's work in the House of Delegates of the American Medical Association has been equally marked by discernment, good common sense and an interest in the long-term advantage of every practicing physician in the nation as well as in the rendition of the best type of medical care to every person who requires it.

During his earlier years on the California delegation to the American Medical Association, he participated very actively in that delegations' program to effect organizational changes in the Association's central office.

When the dark and destructive wave of collectivism began angrily to lash American medicine on the national level, and when, at the St. Louis meeting in 1948, emergency action was imperative, the House of Delegates naturally looked to the California delegation for a plan of voluntary prepayment which would prove effective against the Wagner-Murray-Dingell proposals. In the fight against that legislative incursion, Dr. Askey, our new speaker, took a prominent part. The election of our fellow Californian to that important post serves to remind us anew that only through such capable, well-grounded and constructive leadership as that within the power of Dr. Askey to give can we in medicine even remotely hope to continue to practice our science and art in an economic, political and social milieu which is in any manner conducive to scientific investigation and the widespread application and dissemination of the fruits of such investigations in their practical application to the prevention and treatment of human disease.

LEWIS A. ALESEN, M.D.

The Cancer Commission

Organization, Duties and Activities

[The better to acquaint members of the California Medical Association with the duties and accomplishments of various committees and commissions of the Association, articles such as the one herewith will be published in CALIFORNIA MEDICINE *from time to time.]*

The Cancer Commission of the California Medical Association was established by the following resolution of the House of Delegates of the California Medical Association, adopted in *April 1931* (CALIFORNIA AND WESTERN MEDICINE, 34:432, June 1931):

"*Resolved,* That a permanent Cancer Commission of the California Medical Association be and is hereby created, whose function shall be to represent the California Medical Association in the fight which must be waged upon cancer to the particular ends that:

"1. Adequate means be provided in California for the education of the medical profession in the early diagnosis of cancer;

"2. That more adequate facilities for the diagnosis and treatment of cancer patients be provided;

"3. That research work on the nature, cause, behavior and treatment of cancer be encouraged.

"That said Cancer Commission consist of nine members of the California Medical Association appointed by the president of the California Medical Association; and approved by the Council of the California Medical Association;

"That of the nine members first so appointed, three shall serve one year, three shall serve two years and three shall serve three years and that vacancies as they occur by expiration of term of service or otherwise shall be filled by appointment by the president of the California Medical Association subject to the approval of the Council;

"That three of the nine members of said Cancer Commission be designated by the president of the California Medical Association, respectively chairman, vice-chairman and secretary of the Commission, and that the three members so appointed serve ex-officio as executive committee of the Commission, whose function shall be to conduct the business of the Cancer Commission in the interim between its meetings;

"That said Cancer Commission be and is hereby directed to report to and be guided by instructions of the House of Delegates of the California Medical Association in regular annual convention assembled and that in the interim between said conventions the Cancer Commission be and is hereby directed to report to and receive instructions from the Council of the California Medical Association."

In presenting the resolution to the House, Dr. Alson Kilgore emphasized that the Cancer Commission should cooperate with the American Society for the Control of Cancer, the American College of Surgeons, the State Board of Health and other organized bodies.

The Commission sponsored *lectures and refresher courses* in cancer diagnosis and treatment, and stimulated the development of *consultation services and follow-up services* in many parts of the state. It also lent its aid to the then American Society for the Control of Cancer and to other bodies working for such purposes.

Between 1931 and 1935, the Commission arranged for a series of studies, reports and recommendations on cancer which were published in CALIFORNIA AND WESTERN MEDICINE. In 1936 these were gathered together into a convenient volume entitled, "*C.M.A. Cancer Commission Studies*" (published by J. W. Stacey, Inc., San Francisco). These articles and the succeeding volume had a valuable influence by reflecting up-to-date thought on indications for surgical operation or radiotherapy, and for various combinations of these two main weapons in the fight on cancer.

During the war years (1941-1946), the Commission's activities were restricted, but immediately thereafter, it became active again.

In order to strengthen contacts with the local medical profession and provide a wider basis of representation, the Commission requested the Council of the C.M.A. to authorize the formation of an *Advisory Committee of nine members,* to be appointed annually by the president of the Association for a term of one year. As it was to be an advisory committee, the legal constitution of the Commission did not require alteration. This proposal was approved in May 1946, and since that time it has been the policy of the Commission to submit all matters to the entire *eighteen* members for decision and action.

* * *

American Cancer Society. In 1945 the Council of the California Medical Association authorized the members of the Cancer Commission to serve on the Board of Directors of the California Division of the American Cancer Society, and to cooperate with that organization. In that capacity, the Commission has attempted to advise and assist the program of the A.C.S. in California. In order that there be adequate representation of physicians on the Board of Directors of the A.C.S., six members of the Advisory Committee were selected to serve as directors along with the nine Commission members (the A.C.S. Board then being composed of 15 physicians and 10 lay persons).

Medical Director. In 1946 the Council of the C.M.A. authorized the Commission to employ a full-time medical director to assist the Commission with its numerous functions. This director surveys the Consultative Tumor boards which the Commission has encouraged in approved hospitals; he arranges for cancer education programs in various county medical societies, and for refresher courses in the larger cities. He functions as an active liaison with the cancer committees of the various medical societies, and is a key person in implementing the program of the Commission. He also serves as medical and scientific director of the California Division of the American Cancer Society.

Consultative Tumor boards are to be distinguished from "Cancer Clinics." The function of the tumor board is to provide consultation on the diagnosis and management of problem cases that have been thoroughly studied previously. The board offers group consultation on cases referred from physicians but does not receive patients directly nor make the initial examination or diagnosis. It tends to function most effectively in large teaching hospitals, and where all board members are experienced in cancer work. The Cancer Commission recommends to the California Division of the A.C.S. that funds for secretarial expense be allotted to a board which meets regularly, sees a reasonable number of cancer patients, and adheres to the minimum standards of the Commission, as approved by the Association.

* * *

Between 1947 and 1950 the Commission sponsored a series of new articles on the diagnosis and treatment of cancer, all published in CALIFORNIA MEDICINE and finally collected into one volume entitled *"California Cancer Commission Studies."* This was published by the California Medical Association, 450 Sutter Street, San Francisco, in *1950.* Like the first mentioned studies, this manual aided in clarifying some controversial aspects of cancer diagnosis and therapy. It is now under revision.

* * *

Since its inception, the Cancer Commission has sponsored annual conferences of radiologists and pathologists on cancer problems. These conferences are one-day meetings, and are held on the day preceding the annual meeting of the California Medical Association:

(a) The Pre-Convention Radiological Conference deals with tumor diagnostic problems in the morning, and with tumor therapeutic problems in the afternoon. Members bring films, slides and photographs.

(b) The Pre-Convention Pathological Conference has become known as the Conference on Microscopic Tumor Pathology. Pathologic slides are presented and discussed.

In addition to these pre-convention meetings, the pathologists also hold a mid-winter conference with a similar program.

These pre-convention cancer conferences increase in size each year and are attended not only by specialists in the fields involved but by many other physicians. An attempt is made to show only proved cases, with well-reproduced material, and to have a vigorous chairman who stresses the mutual educational aspects of the program. It can be said that both radiological and pathological proficiency are enhanced by these valuable study meetings.

Cancer Detection Clinics. In response to popular demand, the Commission aided a pilot study of Detection Centers in four communities from 1946 to 1949. Minimum standards for such clinics were adopted in May 1946. The study was summarized and published in February 1950. Detection Centers were found to be uneconomic and relatively ineffective, and the program was terminated in that year. Since 1949, stress has been laid on "The interested physician's own office as a detection center."

Hospitalization of Needy Cancer Patients. Again, in response to popular demand, the Commission aided the California Division of the A.C.S. in carrying out a pilot study on the provision of hospitalization for needy persons in 1947-48. Eligible persons were to be individuals with early, presumably curable cancer, not entitled to local public assistance, not admissible to the local county hospital, and unable to defray their own hospital costs. Approval was to be for a period up to 21 days; fees for professional services were *not* included. The program proved very difficult to administer, and rapidly exceeded the funds allocable by the Society. It had to be terminated.

Cancer Referral Panels. The Commission has urged and set up standards whereby each county medical society can provide (both directly and via the local A.C.S. Information Center) a list of physicians who will make "cancer examinations" and accept cancer patients for treatment. These lists are used on a rotation basis. The Center is asked to maintain a follow-up to assure that a physician has been consulted.

Tumor Registries. The Commission sponsors a C.M.A. Tumor Tissue Registry in the Los Angeles General Hospital, and in response to official requests has aided the State Public Health Department in the development of a California State Tumor Registry on a voluntary basis.

Cancer Surveys. From time to time, representatives of the Chronic Disease Section of the Califor-

nia State Department of Public Health have met with the Cancer Commission in order to work out effective cooperation between the programs of the two bodies. In this regard, the Commission is guided by the fundamental policies of the parent association which are to conduct and finance its work from dues and voluntary contributions, and to avoid, as far as possible, the use of state or federal tax funds for these purposes. In furtherance of a concurrent assembly resolution, the two groups studied the cancer problem from a statewide aspect in 1948; reports on this study were completed by Drs. L. Breslow, State Department of Health, and D. A. Wood of the Commission.*

Cancer Detection Grants. Some members of the Commission, and consultant scientists serve on the Special Grants Committee of the California Division of the American Cancer Society to recommend allocation of grants for cancer research projects financed by the State Division.

* * *

Cancer Remedy and Quackery Investigations. The Commission prepared and disseminated to over 700 newspapers and other public information media in California, a "Statement on Cancer Treatment" in January 1953. This statement was widely publicized and emphasized many facts concerning cancer, notably the fact that there was now available adequate means for testing alleged new remedies. Since 1952 the Commission has conducted intensive studies in connection with three such "remedies" and has published the results of these studies in the state medical journal (CALIFORNIA MEDICINE) as follows:

Laetrile treatment, April 1953.

Arginase treatment, December 1953.

Gregory treatment, April 1954.

In these studies, the Commission was aided by the data from the Bureau of Investigation of the American Medical Association, the state and the federal food and drug administrations and the Committee on Cancer Diagnosis and Therapy of the National Research Council. Unfortunately, all three supposed remedies were found worthless. The Commission's method of procedure in studying and reporting on such nostrums has been commended by many bodies.

The Commission has also disseminated to the medical profession and to the county society branches of the California Division of the American Cancer Society, available facts on other alleged cancer remedies such as the Koch, Hoxsey, Spears, Krebiozen and other "treatments."

*Published in the official State Report on Chronic Disease in California, 1949.

The House of Delegates of the C.M.A. provides funds for the work of the Commission; these are supplemented by a grant from the California Division of the American Cancer Society in order to defray certain administrative expenses.

The Commission reports annually to the House of Delegates of the C.M.A., and periodically between meetings of that House to the Council. Any new policies or projects, such as cytology programs, cancer detection programs and cooperation with cancer surveys, are first cleared with the Council of the C.M.A. before final action by the Commission.

* * *

The officers and members of the Commission and Advisory Committee at the time of preparation of this report are as follows:

Cancer Commission

IAN G. MACDONALD, M.D., *chairman*
DAVID A. WOOD, M.D., *vice-chairman*
L. HENRY GARLAND, M.D., *secretary*
JOHN W. CLINE, M.D.
ALBERT C. DANIELS, M.D.
ERLE HENRIKSEN, M.D.
JOHN M. KENNEY, M.D.
R. A. SCARBOROUGH, M.D.
JUSTIN J. STEIN, M.D.

Advisory Committee

EDWARD M. BUTT, M.D.
JAMES B. GRAESER, M.D.
JAMES E. KAHLER, M.D.
LYELL C. KINNEY, M.D.
CARL MOORE, M.D.
JAMES W. MOORE, M.D.
ROBERT O. PEARMAN, M.D.
VICTOR RICHARDS, M.D.
ROBERT S. STONE, M.D.

Medical Director

W. E. BATCHELDER, M.D.

[This historical summary was prepared by L. Henry Garland, M.D., secretary, April, 1955.]

REFERENCES

Additional data on the functioning of the Cancer Commission may be obtained by review of the annual reports by the chairman or secretary of the Commission which are published in the official journal of the state medical association each year. The following are specific references:

CALIFORNIA AND WESTERN MEDICINE:

36:438, June, 1932—C. A. Dukes, chairman.
38:312, April, 1933—C. A. Dukes, chairman.
40:302, April, 1934—Alson Kilgore, secretary.
42:317, April, 1935—C. A. Dukes, chairman.
44:422, May, 1936—C. A. Dukes, chairman.
46:52, Supplement to April, 1937—A. R. Kilgore, sec'ty.
48:48, Supplement to April, 1938—C. A. Dukes, chairman.
50:52, Supplement to April, 1939—A. R. Kilgore, sec'ty.
52:72, Supplement to April, 1940—Otto Pflueger, sec'ty.
54:202, April, 1941—Otto Pflueger, secretary.
56:220, April, 1942—Otto Pflueger, secretary.
58:202, April, 1943—Harold Brunn, chairman.
60:178, April, 1944—Harold Brunn, chairman.
62:222, April, 1945—Harold Brunn, chairman.
64:220, April, 1946—Lyell C. Kinney, chairman.

CALIFORNIA MEDICINE:

66:201, March, 1947—Lyell C. Kinney, chairman.
68:248, March, 1948—Lyell C. Kinney, chairman.
70:369, April, 1949—Lyell C. Kinney, chairman.
72:325, April, 1950—Lyell C. Kinney, chairman.
74:354, April, 1951—Lyell C. Kinney, chairman.
76:239, March, 1952—R. A. Scarborough, chairman.
78:402, April, 1953—Ian Macdonald, chairman.
80:269, March, 1954—Ian Macdonald, chairman.
82:280, March, 1955—Ian Macdonald, chairman.

ADDITIONAL PUBLICATIONS OF THE COMMISSION (partial list):

1. Cancer Commission Committee Studies, J. W. Stacey, Inc., San Francisco, 1936.

2. Cancer Commission Studies, Calif. Medical Association, San Francisco, 1950.

3. Minimum Standards for Consultative Tumor Boards. Adopted, 1946. Revised, July, 1947, and March, 1950.

4. Minimum Standards for Cancer Detection Centers in California. Approved by C.M.A., May 5, 1946. Discontinued, May 1, 1950.

5. The Cancer Committee of the County Medical Society. D. A. Wood, M.D., January, 1951.

6. Cancer Detection Centers: The Experience in California to Date. L. H. Garland, M.D., California Medicine, 72:99, February, 1950.

7. Cancer Diagnostic Facilities and Detection Centers—Editorial. J.A.M.A., 138:132, 1948.

8. Cancer Detection: A County Medical Society Program, Riverside, California. L. H. Garland, M.D., and C. P. McCullough, M.D. California Medicine, 80:65, February, 1954.

9. Cancer of the Female Genital Tract: Recommendations. California Medicine, 81:70, 1954.

In Memoriam

CHENEY, GARNETT. Died in San Francisco, June 16, 1955, aged 56, of carcinoma. Graduate of Harvard Medical School, Boston, Massachusetts, 1923. Licensed in California in 1925. Doctor Cheney was a member of the San Francisco Medical Society.

✤

GRAY, JOHN R. Died in San Jose, April 22, 1955, aged 82, of hypostatic pneumonia, hypertensive coronary disease, and diabetes mellitus. Graduate of the Lincoln Medical College, Eclectic, Nebraska, 1902. Licensed in California in 1922. Doctor Gray was a retired member of the Monterey County Medical Society, the California Medical Association, and an associate member of the American Medical Association.

✤

LANE, EDWARD H. Died in Los Angeles, June 27, 1955, aged 80. Graduate of The Hahnemann Medical College and Hospital, Chicago, Illinois, 1898. Licensed in California in 1927. Doctor Lane was a member of the Los Angeles County Medical Association.

✤

LEONARD, EILEEN M. Died in San Francisco, May 30, 1955, aged 59. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1922. Licensed in California in 1922. Doctor Leonard was a member of the San Francisco Medical Society.

ROOT, III, JOSEPH L. Died in Orange, June 13, 1955, aged 47, of adenocarcinoma of cecum. Graduate of the New York Medical College, Flower and Fifth Avenue Hospitals, New York, 1949. Licensed in California in 1950. Doctor Root was a member of the Orange County Medical Association.

✤

SHAMBAUGH, NOEL F. Died in Long Beach, May 30, 1955, aged 59. Graduate of the University of Michigan Medical School, Ann Arbor, 1922. Licensed in California in 1929. Doctor Shambaugh was a member of the Los Angeles County Medical Association.

✤

WEES, MARSHALL P. Died in La Jolla, June 15, 1955, aged 49, of coronary occlusion. Graduate of the University of Michigan Medical School, Ann Arbor, 1943. Licensed in California in 1946. Doctor Wees was a member of the San Diego County Medical Society.

✤

WILLIAMSON, MARK A. Died in Encinitas, June 2, 1955, aged 76, of abdominal carcinoma. Graduate of the Cooper Medical College, San Francisco, 1902. Licensed in California in 1902. Doctor Williamson was a retired member of the Kern County Medical Society, the California Medical Association, and an associate member of the American Medical Association.

WOMAN'S AUXILIARY
TO THE CALIFORNIA MEDICAL ASSOCIATION

THE STORY GOES that when your Woman's Auxiliary was first organized in 1929, it was greeted with good-natured tolerance. If the women wanted another excuse for tea parties, well and good!

As 26 years of history has proven, however, the Woman's Auxiliary to the California Medical Association turned out to be anything but "just another woman's club." From small beginnings—49 charter members—it has grown to be the largest Auxiliary in the nation. With the recent addition of 24 charter members of the Merced County Auxiliary, membership topped 6,000.

The list of achievements is even more impressive. Here are a few facts and figures:

During the past year your Auxiliary contributed close to $18,000 to nurse recruitment, of which at least $14,000 went to scholarships, thus speeding hundreds of young women on their way to relieving the nursing shortage. . . . There are now 56 Future Nurse clubs sponsored by the Auxiliary throughout the state. . . . Since 1949, nearly $60,000 has been earmarked by the Auxiliary for nurse recruitment. Add to this an immeasurable amount of public interest in nursing as a career which has been stirred up. Last year the Auxiliary put $5,217.99 into the coffers of the American Medical Education Foundation.

While primarily *not* a money-raising group, your Auxiliary contributed over $3,000 to Physicians' Benevolence Fund last year, bringing the grand total of donations to this fund to approximately $33,000 in the past 14 years.

Your Auxiliary works hand in hand with its Advisory Board. Current members of this board are Dr. Sidney Shipman, Dr. Donald A. Charnock, Dr. A. Justin Williams, Dr. Daniel Morton, Dr. Albert Daniels. The Auxiliary affiliates with no other federated organization without a go-ahead from the Advisory Board—checks all its policies and activities with the board.

Your Auxiliary is a member of the National Safety Council; a part of the Crusade for Freedom; a part of the World Medical Association.

Last year the Woman's Auxiliary was commended by the California State Legislature for being "an organization which has rendered many valuable services throughout the State of California." . . . Members keep up-to-date in legislative affairs on both the state and national level.

Although your Auxiliary handled tens of thousands of dollars last year, it functioned on an income of just $5,864. (Auxiliary books are audited on April 15 of each year, and a financial report is issued on the membership in May.) . . . Dues in the County Auxiliaries vary from $3 to $10 a year. Of this, $1 goes to the National Auxiliary, $1 to the State Auxiliary, the remainder to the County Auxiliary. Physicians' wives in counties where there is no Auxiliary may join the State Auxiliary for just $2 a year, and so enjoy its privileges (including a subscription to *Courier*) and a share in its interesting program.

Last year, your Auxiliary accounted for 2,770 new subscriptions to *Today's Health*, over 62 per cent of its quota. (When subscribed through an Auxiliary member the price is a thrifty $1.50 instead of the regular $3.) . . . Members of the Auxiliary devote time and talent to many health service organizations, including the American Cancer Society, the Heart Association, the Crippled Children's Society, the Red Cross. Members help staff blood banks all over the state.

Two members of the Auxiliary have served as president of the Woman's Auxiliary to the A.M.A.—Mrs. James F. Percy, 1932-33; Mrs. Ralph Eusden, 1952-53. . . . Mrs. Carl Burkland, former state president, was reappointed secretary of the National Auxiliary for 1955-56.

Your Auxiliary feels that it can make one of its greatest contributions through community service—that through the performance of its individual members it can best promote friendship and understanding for the medical profession. . . . Members double their efforts at Christmastime to work on community projects, bringing Christmas cheer to the aged, the ill, the crippled and the shut-in.

Your Woman's Auxiliary has as its constant aim the bettering of public relations for the medical profession, the promotion of better understanding in the fields of medicine and public health.

The Woman's Auxiliary has 32 county auxiliaries organized out of a possible 40—6,002 individual members compared to the 13,500 members of the C.M.A.

The Los Angeles County Auxiliary is the largest County Auxiliary in the country, with 1,660 members. This tops the membership in state auxiliaries of 13 other states.

The state magazine *Courier* has been nationally commended, year after year, as the best publication in its field.

At the recent convention of the National Auxiliary in Atlantic City, your State Auxiliary received two awards from A.M.E.F. . . . participated on the legislation panel and the publications panel.

Your Auxiliary takes an active part in Civil Defense, sponsoring programs in its various counties. It is also active in mental health. An auxiliary committee is set up to work with the American Medical Association in self-education to determine our mental health facilities and resources.

Members get behind fund-raising projects with enthusiasm . . . last year $3,005.42 was rung up in one county fund-raising project alone.

Behind all this activity there is a great deal of organization and work. So that you may become well acquainted with your Auxiliary and how it functions, we are planning to bring you informative articles about several of our different activities during the year.

Annual Meeting

Ambassador Hotel

LOS ANGELES

April 29 - May 2, 1956

Papers for Presentation

If you have a paper that you would like to have considered for presentation, it should be submitted *to the appropriate section secretary* (see list on this page) not later than November 19, 1955.

Scientific Exhibits

Space is available for scientific exhibits. If you would like to present an exhibit, please write immediately to the office of the California Medical Association, 450 Sutter Street, San Francisco 8, for application forms. To be given consideration by the Committee on Scientific Work, the forms, completely filled out, must be in the office of the California Medical Association not later than December 1, 1955. (No exhibit shown in 1955, and no individual who had an exhibit at the 1955 session, will be eligible until 1957.)

SCIENTIFIC PAPERS

SCIENTIFIC EXHIBITS

PLANNING MAKES PERFECT

AN EARLY START HELPS

SECRETARIES OF SCIENTIFIC SECTIONS

ALLERGY . . . . . **William J. Kerr, Jr.**
711 D Street, San Rafael

ANESTHESIOLOGY . . . . . **Robert W. Churchill**
1180 Montgomery Drive, Santa Rosa

DERMATOLOGY AND SYPHILOLOGY . . **Anker K. Jensen**
1052 West Sixth Street, Los Angeles 17

EAR, NOSE AND THROAT . . . . **E. Gordon McCoy**
490 Post Street, San Francisco 2

EYE . . . . . **Channing W. Hale**
174 Nemaha Street, Pomona

GENERAL MEDICINE . . . . . **Harold C. Sox**
300 Homer Avenue, Palo Alto

GENERAL PRACTICE . . . . . **T. Jackson Laughlin**
10910 Riverside Drive, North Hollywood

GENERAL SURGERY . . . . . **Orville F. Grimes**
U. C. Medical Center, San Francisco 22

INDUSTRIAL MEDICINE AND SURGERY . . . . . **Homer S. Elmquist**
629 So. Westlake Avenue, Los Angeles 57

OBSTETRICS AND GYNECOLOGY . . . **Ralph C. Benson**
U. C. Medical Center, San Francisco 22

ORTHOPEDICS . . . . **A. B. Sirbu (Acting Secretary)**
450 Sutter Street, San Francisco 8

PATHOLOGY AND BACTERIOLOGY . . **Justin R. Dorgeloh**
378 Thirtieth Street, Oakland 9

PEDIATRICS . . . . . **Moses Grossman**
U. C. Medical Center, San Francisco 22

PSYCHIATRY AND NEUROLOGY . **William F. Northrup, Jr.**
696 East Colorado Street, Pasadena 1

PUBLIC HEALTH . . . . . **Wilbur J. Menke, Jr.**
City Hall, Pasadena 1

RADIOLOGY . . . . . **Austin R. Wilson**
540 North Central Avenue, Glendale 3

UROLOGY . . . . . **Edmund Crowley**
1930 Wilshire Boulevard, Los Angeles 57

NEWS & NOTES

NATIONAL • STATE • COUNTY

ALAMEDA

A grant of $23,149 by the National Foundation for Infantile Paralysis to the California State Department of Public Health to provide supplementary **funds for research** to develop a simple diagnostic test for poliomyelitis was announced recently. The work will be under the direction of Dr. Edwin H. Lennette, chief of the health department's Viral and Rickettsial Disease Laboratory.

At the same time it was announced that the University of California at Berkeley received $85,198 from the foundation for continuance of **studies to determine the chemical composition of the virus** that causes poliomyelitis. This research is being carried on by Dr. Wendell M. Stanley, director of the Virus Research Center on the Berkeley campus.

Dr. Stanley also was awarded a supplementary grant of $1,790 by the **American Cancer Society** to continue a cancer research project.

LOS ANGELES

The following officers of the **Radiological Society of Southern California** were installed in June to serve for the remainder of 1955 and the first half of 1956: Chairman, Dr. Lowell S. Goin, Los Angeles; vice-chairman, Dr. John D. Camp, Los Angeles; secretary-treasurer, Dr. James B. Irwin, San Diego. Other members of the Board of Directors are: Dr. Donald R. Laing, Pasadena, and Dr. George Jacobson, Los Angeles.

* * *

A $100,000 trust fund for **cancer research** at the Medical Center on the Los Angeles campus of the University of California has been established by James and Lorena Greims of Encino, Calif.

The fund will be used for certain surgical problems associated with cancer under the direction of Dr. G. A. Stevens, clinical professor of surgery. He will be assisted by Dr. David B. Shelton.

The research will be concerned with three different problems:

1. A study of factors which control growth of abnormal cells within the body.

2. Development and perfection of new operations for cancer treatment.

3. A study of the body processes and their control in the cancerous patient and the alteration of these processes following the removal of the cancer by operation.

* * *

Dr. Carroll J. Bellis of Long Beach, senior consultant in surgery at Long Beach General Hospital, has been declared the winner of the 1955 Mississippi Valley Medical Society essay contest for his paper "The Management of Acute Bowel Obstructions." Dr. Bellis will present the paper at the 20th annual meeting of the Mississippi Valley Medical Society to be held at the Jefferson Hotel, St. Louis, September 28-30. He will receive a gold medal, a certificate and a cash award.

The Southern California Psychiatric Society is publishing a Directory of Psychiatrists in Southern California. Any psychiatrist in the area who has not received an information sheet is urged by the Society to request it immediately from Jerome M. Kummer, M.D., associate editor, Box 305, Santa Monica.

* * *

Two top **administrative posts for physicians** with public health experience are now available in the Los Angeles City Health Department, it was announced recently. Additional positions in clinical medicine are also open.

Applications are now being received for the position of medical director, a post involving the direction and administration of the following departmental services: Communicable disease control (including tuberculosis and venereal disease control), maternal and child health, adult health, laboratories, and public health nursing. The salary range is $797 to $992 a month. In addition, the department is seeking a well qualified epidemiologist with formal training in public health, special experience in communicable disease control and administrative abilities. This position pays $715 to $889 a month.

Openings for chest specialists for clinical duties in the tuberculosis control service are available at salaries ranging from $608 to $775.

None of these positions requires a competitive civil service examination, the Department said. Further information may be obtained from H. C. Pulley, M.D., Los Angeles City Health Department, 111 East First Street, Los Angeles 12.

ORANGE

Dr. Harold M. F. Behneman, Laguna Beach, has been appointed to the staff of the American College of Surgeons as a field representative, Dr. Paul R. Hawley, director of the College, announced recently. Dr. Behneman will survey cancer detection and treatment facilities in the West, Northwest and western Canada. Serving also as College representative to the Joint Commission on Accreditation of Hospitals, he will survey hospitals in this area.

SAN FRANCISCO

Following is the program for the **Cancer Conference** of the California Division of the American Cancer Society to be held Friday afternoon, September 30, 1955, at the St. Francis Hotel, San Francisco:

2:00—Diagnostics in Cancer Work—John G. Walsh, M.D., Sacramento.

2:30—Current Virus Research Applied to the Cause of Cancer—Dr. W. M. Stanley, Berkeley.

3:00—Current Status of Environmental Factors in Lung Cancer—Paul Kotin, M.D., Glendale.

3:30—Psychological Impact of Cancer on the Patient and Family—Robert Crede, M.D., San Francisco.

4:00—Cancer of the Stomach in Hawaii—Walter B. Quisenberry, M.D., Honolulu.

* * *

Stanford University has received a total of $200,000 for medical fellowships from the estate of the late Charles Francis Aaron of Marysville, it was announced recently by Wallace Sterling, president.

Provided in continuing payments since Mr. Aaron's death in 1953, the money comprises the **Charles Francis Aaron Endowment Fund** as stipulated by his will. He arranged that it should be used to help "unusually qualified, but needy, recent graduates in medicine, for training in research of special fields."

The names of five of the guest speakers who will appear on the program of the 26th Annual **Postgraduate Symposium on Heart Disease** which is to be held October 5-7 at the St. Francis Hotel, were announced recently by the San Francisco Heart Association. They are: Dr. D. Evan Bedford of London, England, Dr. Franklin D. Johnston of Ann Arbor, Dr. Elliot V. Newman of Nashville, Dr. Edith Potter of Chicago, and Dr. Myron Prinzmetal of Los Angeles.

Cooperating with the San Francisco Heart Association in the presentation of this program will be six other Northern California County Heart Associations, Alameda, Marin, Monterey, San Mateo, Santa Clara, and Sonoma.

GENERAL

The 12th annual meeting of the **American Medical Writers' Association** will be held at the Hotel Jefferson, St. Louis, September 30, followed by an Association-sponsored Workshop on Medical Writing, October 1.

All physicians and collegiate graduates interested in medical writing, journalism or publishing are invited to attend the meeting and to become Association members. There is no registration fee for attending the meeting but a registration fee of $5 for the Workshop is required of nonmembers.

* * *

The **Arthritis and Rheumatism Foundation** is offering the following research fellowships in the basic sciences related to arthritis: (1) Predoctoral fellowship ranging from $1,500 to $3,000 per annum, depending on the family responsibilities of the fellow, tenable for one year with prospect of renewal. (2) Postdoctoral fellowships ranging from $4,000 to $6,000 per annum, depending on family responsibilities, tenable for one year with prospect of renewal. (3) Senior fellowships for more experienced investigators will carry an award of $6,000 to $7,500 per annum and are tenable for five years.

The deadline for applications is October 15, 1955. Applications will be reviewed and awards made in January 1956.

Information and application forms may be obtained from The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

* * *

The **American Dermatological Association** has announced the offering of a series of prizes for the best essays submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. Cash prizes will be awarded as follows: $500, $400, $300, and $200 for first, second, third and fourth place, respectively. Competition in this prize contest is open to scientists generally, not necessarily to physicians. Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts and tables, all of which must be in triplicate, are to be submitted not later than November 15, 1955.

The manuscripts should be sent to Dr. J. Lamar Callaway, secretary, American Dermatological Association, Duke Hospital, Duram, North Carolina.

* * *

The **Seventh Annual Symposium on Heart Disease,** sponsored by the **Washington State Heart Association** and the Washington State Department of Health, will be held September 30 and October 1 in the University of Washington Medical School Auditorium, Seattle. Among the speakers will be Dr. Howard Sprague of Boston, Dr. Charles Kossman of New York City, and Dr. Jesse Edwards of the Mayo Clinic, Rochester, Minn.

POSTGRADUATE EDUCATION NOTICES

THIS BULLETIN of the dates of postgraduate education assemblies and the meetings of various medical organizations in California is supplied by the Committee on Postgraduate Activities of the California Medical Association. In order that they may be listed here, please send communications relating to your future medical or surgical programs to: Mrs. Margaret H. Griffith, Assistant Director, Postgraduate Activities, California Medical Association, 417 South Hill Street, Los Angeles 13.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Anesthesia—August 29, 30 and 31, 1955.

Surgical Anatomy, Tuesday evenings, September 20 to November 22, 1955.

Advanced Treatment of Emotional Problems, Thursday evenings, September 22 to December 15, 1955.

Annual Medical Lecture Series, Monday evenings, September 26 to December 12, 1955.

Application of Principles of Industrial Medicine to Private Practice, Wednesday afternoons, October 19 to December 14, 1955.

Aviation Medicine, Tuesday, Wednesday and Thursday, October 25, 26 and 27, 1955.

Pediatrics, Thursday, Friday and Saturday, October 27, 28 and 29, 1955.

Three Symposia: RIVERSIDE, Wednesdays, September 21, 28 and October 5, 1955—(a) What's New in Medicine; (b) Fevers of Unexplained Origin; (c) Obstetrics.

Three Symposia: SAN DIEGO, Wednesdays, October 26, November 2 and 9, 1955—(a) Radioisotopes; (b) Surgery of the Hand; (c) Burns, one-half day; Repair of Superficial Wounds, one-half day.

Contact: Thomas H. Sternberg, M.D., Assistant Dean for Postgraduate Medical Education, U.C.L.A., Los Angeles 24.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

In San Francisco:

Conference on Applied Therapeutics—October 17, 18 and 19.

Conference on Gynecology and Obstetrics—October 20 and October 21.

Ophthalmological Conference—December 5 to December 7.

In East Oakland:

Medicine for General Practitioners—Tuesday evenings, September 20 to December 6.

In Berkeley:

Postgraduate Institute—Wednesday evenings, Herrick Memorial Hospital, October 19 through November 23.

In San Mateo:

Evening Lectures in Medicine—Thursday evenings, September 22 to December 15.

Contact: Office of Medical Extension, University of California Medical Center, San Francisco 22.

UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

In Ventura:

No. 843: Recent Advances in Diagnosis and Treatment. In cooperation with the Ventura County Medical Association. Six weekly lectures, September 29 to November 3, 1955.

In Los Angeles:

No. 873: Cardiac Resuscitation. Sponsored by the Los Angeles County Heart Association, each Wednesday throughout the year, U.S.C. Medical Research Building.

Contact: Office of Medical Extension Education, University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 33.

STANFORD UNIVERSITY

Important Recent Advances in Treatment in General Practice. September 12, 13, 14, 1955. 9 a.m. to 4:30 p.m. Fee, $75.00.

Recent Advances in General Surgery and Surgical Anatomy. September 12 through 16, 1955. 8:30 a.m. to 4:30 p.m. Fee, $125.00.

Contact: Jay Ward Smith, M.D., Associate Dean and Director of Postgraduate Education, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco.

COLLEGE OF MEDICAL EVANGELISTS

Announces graduate courses:

General Surgery and Surgical Specialties—October 2 to June 8, 1956.

Internal Medicine—October 2 to June 8, 1956.

Otolaryngology—October 2 to June 8, 1956.

Contact: Chairman, Section on Graduate and Postgraduate Medicine, College of Medical Evangelists, 1720 Brooklyn Ave., Los Angeles 33.

CALIFORNIA MEDICAL ASSOCIATION, POSTGRADUATE ACTIVITIES CIRCUIT COURSES

NORTH COAST CIRCUIT:
Eureka—Monday, October 17, 24, 31, November 7.
Ukiah—Tuesday, October 18, 25, November 1, 8.
Woodland—Wednesday, October 19, 26, November 2, 9.
Napa—Thursday, October 20, 27, November 3, 10.

SACRAMENTO VALLEY CIRCUIT:
Dunsmuir—Monday, October 17, 24, 31, November 7.
Chico—Tuesday, October 18, 25, November 1, 8.
Marysville—Wednesday, October 19, 26, November 2, 9.
Auburn—Thursday, October 20, 27, November 3, 10.

Contact: C. A. Broaddus, M.D., Director of Postgraduate Activities, P.O. Box A-1, Carmel, California.

Medical Dates Bulletin

AUGUST MEETINGS

STATE BOARD OF MEDICAL EXAMINERS Oral Examination for Reciprocity Applications, Los Angeles, August 20.†

STATE BOARD OF MEDICAL EXAMINERS Written Examination, Los Angeles, August 23-25.†

STATE BOARD OF MEDICAL EXAMINERS Oral and Clinical Examinations for Foreign Medical School Graduates, Los Angeles, August 21.†

SEPTEMBER MEETINGS

SAINT JOHN'S HOSPITAL announces its Seventh Annual Postgraduate Assembly, September 12, 13 and 14, Elk's Club, Santa Monica. All physicians invited to attend. Registration fee, $10.00.

Contact: John C. Eagan, M.D., Director, Postgraduate Assembly, St. John's Hospital, 22nd Street at Santa Monica Blvd., Santa Monica.

OCTOBER MEETINGS

CALIFORNIA SOCIETY OF INTERNAL MEDICINE meeting at Biltmore Hotel, Santa Barbara, October 1, 1955.

Contact: Mildred D. Coleman, secretary, 384 Post St., San Francisco.

SAN FRANCISCO HEART ASSOCIATION announces the Twenty-sixth Annual Postgraduate Symposium on Heart Disease, at St. Francis Hotel, San Francisco. October 5, 6, 7, 1955.

Contact: 604 Mission St., San Francisco 5.

SAN DIEGO COUNTY HEART ASSOCIATION Annual Symposium on Heart Disease, U. S. Naval Hospital, Auditorium, Balboa Park, San Diego, October 11.

Contact: H. Jack Hardy, executive secretary, 1651 Fourth Avenue, San Diego.

LOS ANGELES COUNTY HEART ASSOCIATION 25th Annual Symposium on Cardiovascular Diseases, Wilshire-Ebell Theater, Los Angeles, October 12 and 13.

Contact: Los Angeles County Heart Association, 316 So. Bonnie Brae Street, Los Angeles.

The 1955 Scientific Assembly of the CALIFORNIA ACADEMY OF GENERAL PRACTICE will be held in San Francisco, at the Sheraton-Palace Hotel, October 9-12, 1955.

Contact: William W. Rogers, executive secretary, 461 Market St., San Francisco.

STATE BOARD OF MEDICAL EXAMINERS Written Examination, Sacramento, October 18-20.†

Mid-October—AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY Examinations, San Francisco.

Contact: David A. Boyd, M.D., Secretary, 102-110 Second Avenue, S.W., Rochester, Minn.

NOVEMBER MEETINGS

AMERICAN MEDICAL ASSOCIATION announces: Clinical Session, 1955, at Boston, November 29 to December 2, 1955.

STATE BOARD OF MEDICAL EXAMINERS Oral Examination for Reciprocity Applications, San Francisco, November 12.†

STATE BOARD OF MEDICAL EXAMINERS Oral and Clinical Examinations for Foreign Medical School Graduates, San Francisco, November 13.†

JANUARY MEETINGS

LOS ANGELES MIDWINTER MEDICAL CONVENTION, January 3, 4, 5, 1956, Biltmore Hotel, Los Angeles. An 85th anniversary, sponsored by Los Angeles County Medical Association.

Contact: Jerry L. Pettis, Public Relations Counsel, Los Angeles County Medical Association, 1925 Wilshire Blvd., Los Angeles 57. Telephone DUnkirk 5-1581.

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†*For information contact:* Louis E. Jones, M.D., secretary-treasurer, California State Board of Medical Examiners, Room 536, 1020 N Street, Sacramento. (Note: Applications must be on file at least two weeks before examination dates.)

INFORMATION

California Conference on Physicians and Schools

PATRICIA HILL
Consultant in School Health Education, California State Department of Education

THE FIRST California Conference on Physicians and Schools was held in Fresno, November 12-13, 1954, with more than 250 members of the educational, public health and medical professions participating. The purpose of the conference was to develop means by which the three professions can more closely coordinate efforts toward improving the protection of the health of California's school children. The conference was sponsored by the California Medical Association in cooperation with the State Department of Education and Public Health.

Four national conferences on physicians and schools have been held in recent years and the California conference is an outgrowth of these conferences. Representatives of local school districts and the sponsoring agencies who have attended one or more of the national conferences served on the planning committee for the California conference. Just as the national conferences have served as a stimulus for state conferences, it is hoped that the state conference will motivate personnel in local schools, public health departments, and medical societies to plan similar conferences on a regional level.

Superintendent of Public Instruction Roy E. Simpson, in his welcoming address to the participants at the California conference, pointed out that educators, public health personnel and physicians in private practice are all working with the same families. He stated further "that the health of California's school children plays a major role in the total educational program. The modern school deals with physical, mental, emotional and social development of each pupil. As child health is improved, other aspects of school endeavor are more successful. To learn effectively, children need good health."

Dr. Simpson emphasized that school health programs are not conducted in a vacuum, but are carried on in communities in which many individuals and agencies are vitally concerned with child health, and stated that "parents, physicians and dentists, health personnel serving the schools, the administrative and teaching staffs of schools and members of various community agencies all have important responsibilities in maintaining and promoting the health and welfare of the school-age child."

"I believe," said Dr. Simpson, "it is an important step forward to sit down together as we are doing at this conference to work out an interprofessional approach to some of our mutual problems."

Orientation to the conference was given by Fred V. Hein, Ph.D., consultant in Health and Fitness, Bureau of Health Education, American Medical Association, in a discussion of the "Scope of School Health." In opening his talk Dr. Hein stated that many people ask the question—"Why should the schools have a health program?" He presented the following answers to such a question:

1. Some children come to school with health problems that interfere with their ability to learn effectively. Methods to discover such blocks to learning and to encourage correction to bring about adjustment to them are essential.

2. In even the best organized schools a certain amount of sudden illness and some accidents are bound to occur. This makes procedures for dealing with emergencies, including large-scale disasters, a practical necessity.

3. Communicable disease is likely to spread readily among children gathered together in the close proximity of the school room. This obligates the school to institute and practice appropriate preventive and control measures.

4. During the school year children are compelled by law to spend several hours a day within the school and its environs. This, in turn, places a responsibility upon the school to provide a safe and healthful environment—mental and emotional as well as physical.

5. The school years present a unique opportunity for health education; tomorrow's citizens are grouped in an instructional situation during the formative period of their lives. Unless a golden opportunity is to be lost, this demands well-designed and progressive health education throughout the school grades.

To meet the needs stated or implied in the foregoing answers, Dr. Hein stated that "A carefully developed three-point health program, including health services, healthful school living and health education, is required." He described each phase and pointed out that the providing of such a program is too big a job for any one group, as it required a great variety of professional experience and training.

In stressing the need for cooperation between schools and physicians, Dr. Hein stated, "There must be mutual respect for the skills and abilities of each profession. For example, the educator turns to the physician for guidance on the medical phases of school health, but remains secure in the knowledge that its educational aspects are equally important. On the other hand the physician recognizes the value of educational 'know-how' and realizes that the contributions of both professions are essential to any worth while program of school health."

Reprinted from *California Schools*, April, 1955, by permission of the State Department of Education.

EIGHT DISCUSSION GROUPS

Following the opening session, the participants grouped themselves into eight sections for discussion of the following specific topics: Communicable Disease; Health Guidance and Physical Education; Emotional Problems of Young Children; Environmental Aspects of School Health; Children with Special Health Problems; Personal Physician and School Health; School Physician and School Health and Emergency Care. Membership in each section was composed of school administrators, teachers, school physicians, school nurses, physicians and dentists in private practice, professional personnel from local health departments, and representatives from the State Departments of Education and Public Health. Highlights of the discussion and the recommendations made by each group were as follows:

REPORTS OF DISCUSSION GROUPS

Group I—Communicable Disease

Members of Group I agreed that the objective in control of communicable disease is "the maximum application of existing knowledge for the conservation of optimal health and well-being of the school-age child and for the prevention of illness, disability, and death from communicable disease." This group urged that *all* children be immunized by their family physicians early in life and prior to entering school. They felt that the school has a definite role in the interpretation of the need for adequate immunization, in encouraging parents to have their children protected before entering school, and in maintaining an adequate level of immunization in the entire community. Members of the group agreed that immunizations and vaccines should be administered, preferably, by physicians in their offices or by the community medical facilities rather than in school immunization programs.

The discussion group made the following specific recommendations:

1. There should be a continuing review, by appropriate persons, of the Health and Safety Code, Education Code, state regulations, and local ordinances and regulations to keep communicable disease aspects up-to-date.

2. Up-to-date information should be utilized and attitudes developed which will encourage desirable practices concerning "minor" illnesses such as colds, "flu," etc.

3. Medical and allied resources should continue to re-examine policies and practices in light of newer knowledge, and changes in these should be made accordingly. Sound, *flexible* policies should be formulated on the basis of current scientific facts, *local* attitudes and situation. These policies should be formulated by those individuals and groups concerned.

Group II—Health Guidance and Physical Education

For the purpose of discussion, the group accepted the following definitions:

1. "Health guidance" involves *all* measures from *all* persons giving instruction or services for health, including physicians, school physicians, school nurses, classroom teachers, school administrators, physical education teachers, parents, personnel from voluntary health agencies, and any others who may have contact with the child.

2. "Physical education" is a way of education through and of the physical and its purposes are in harmony with other areas of education.

Group discussion centered around the purposes of physical education, the type of program needed to achieve these purposes, and the need for cooperative planning by all personnel involved in health guidance. Following is a condensation of the recommendations made by members of Group II:

1. There should be a greater emphasis on health guidance and physical education in the elementary grades because these are the most formative years. . . .

2. The physical education program in secondary level should include various types of activities adjusted to individual needs. Athletics should be included in the program with necessary safeguards to insure benefits in participation for all girls and boys. Community pressures for winning teams need to be changed to support an all-around program.

3. Qualified personnel (persons with a professional degree in the field in which they are working, from a recognized accredited institution) should be actively concerned with programs of competition that are being developed in the communities. The standards that have been set up by national committees and which have been approved and accepted by national and local educational groups should be the basic standards used in all instances. . . .

4. The size of physical education classes should be comparable to those in other areas if the physical educator is to make his contribution to the health education guidance program.

5. A school health committee with representation from all health guidance groups should be set up on a local level and services from each of these groups should be available for each of the other groups. . . .

6. Cumulative records are essential if health guidance programs are to meet the needs of boys and girls. . . . It was suggested that a narrative type of record is desirable. . . . The record must be good to be used and be used to be good.

7. It is essential that all health guidance personnel have adequate professional preparation for specific roles on the health guidance team and each be willing to work with other groups. Each group should have knowledge concerning the work of other groups. For example, physicians should know the nature of the physical education program, as this would influence granting of physical education excuses.

8. The school administrator, because of his key position in the health guidance program, needs to have the interest in and the knowledge of the health needs of the students.

9. Teacher-education institutions should include more health education in the professional preparation of all teachers and administrators.

10. Health services in schools should be under the direct administrative control of physicians who have special preparation in school health administration and, lacking availability of such personnel, school administrators should seek the help of the local medical society in setting up policies for school health practices applicable to the local situation.

11. Local medical societies have an obligation to exert positive leadership in the development of good school health programs in the schools of their geographic areas. Since the local school administrator is responsible for all activities within his school, such leadership should be exerted at the top administrative level, seeking a cooperative approach through joint committees with representation from the medical professions, public health, physical education and others interested in the health of the school child.

12. Graduate education for physicians participating in school health guidance programs should be encouraged.

13. The curriculum planning committee of medical schools should give consideration for the inclusion of appropriate amounts of time for instruction in the role of the physician in health programs for school-age children.

Group III—Environmental Aspects of School Health

The members of the group agreed that the term "healthful environment," applies to all the external factors that affect the health of the school child while he is under the jurisdiction of the school. The group also agreed that the purposes of creating or promoting healthful environment are to improve health and healthful living of those in the school; to further health education; to improve home conditions through learning experiences at school; to provide healthful relationships between all persons involved in the school program; to provide a setting for good instruction. The group discussed the responsibilities and services of various individuals and agencies in providing and maintaining a healthful environment, considering both legal and nonlegal responsibilities. Members of the group made the following recommendations:

1. That studies or surveys be made in view of the changing architectural plans to determine what effects they have on the emotional-physical life of the child.

2. In view of the overcrowded conditions of many of our schools, that we work toward smaller-sized classes with properly trained teachers and ancillary personnel.

3. That efforts be directed toward obtaining adequate facilities for improving the environment of the school health program.

4. In order to attain adequate health environment for school children, that all health services in the community be called upon as fully as possible.

5. That a clear method of communication between the school and the physician be devised.

6. Through his county and state organizations, the doctor and the dentist should support programs for improving a healthful and beneficial environment for the child.

Group IV—Emotional Problems of Growing Children

Members of Group IV assumed at the outset of their discussion that health is a primary objective of modern education and that mental health is an integral part of health. Mental health was described, for the purpose of discussion, as a condition that manifests itself in school children in at least the following three ways: *First,* the mentally healthy child displays an emotional development which is commensurate with his physical and intellectual age, if not his chronological age. *Second,* he makes use of, and is developing, his capacities to the greatest degree. *Third,* he is able to carry on a satisfying and constructive relationship with his peers.

In the opinion of the group, a clear-cut division between mentally healthy and mentally unhealthy children cannot be made. All children, in growing up, have emotional and social problems, and the schools must provide an emotional atmosphere which is conducive to the normal emotional and social development of all children. The first step in providing such an atmosphere, the group agreed, depends upon the selection and training of teachers and school administrators who are healthy, emotionally mature, and who understand the emotional and social needs of children as well as their edutional needs.

Considerable time was spent in discussing how the various professional people concerned with childhood health can learn to work together. Included in these professional roles were not only the family physician, the public health officer, and the educator, but also the nurse, the psychologist, the psychiatric social worker, and the psychiatrist. Participants stressed communication as an exceedingly vital factor in the solution of children's emotional problems.

Members of Group IV made the following recommendation:

In each sufficiently large school district, and through the county school offices with regard to smaller districts, advisory health committees should be set up, with representatives from such agencies as: County Medical Society, County Dental Society, Public Health Department, Voluntary Health Agencies, social agencies, and Nurses Association. These committees should be formed at the invitation of the school, with representatives appointed by the respective agencies, and should be concerned with both the mental and physical health of the children.

Group V—Children with Special Health Problems

Members of Group V agreed on the following basic premise applicable to children with special health problems: Wherever possible, the experiences common to normal children should be utilized in the education of the handicapped child. Thus, the common characteristics would be capitalized, rather than the idiosyncrasies of the handicapped. Members of the group felt that one of the most important steps in complying with the premise is early casefinding of children with special health problems, in which cooperation of the personal physician and the pediatrician seems essential. They also felt there should be greater utilization of existing casefinding procedures of school and health departments, and improved channels of communication between private physicians and community agencies.

Accurate appraisal of the child's status should enable the teacher to utilize the correct teaching

procedures. Members of Group V also felt that education of parents toward acceptance and understanding of the particular health needs of their child is important in the development of better school health programs for children with special health problems. The group made the following recommendations:

1. That the general health of the child under treatment for a physical handicap be considered important and that this child receive continued supervision from the family physician or pediatrician as a coordinator.

2. That there be established minimum requirements for facilities and services for handicapped children on a county level.

3. That conferences similar to this be held on a local or regional basis.

4. That more education and guidance be provided for parents toward their acceptance and understanding of the particular health needs of their children.

Group VI—Personal Physician and School Health

The role of the personal physician and his county medical society in making effective a sound school health program cannot be overemphasized, according to members of Group VI. However, the discussion indicated that more education, regional and local, is needed before the active cooperation and assistance of the physicians can be assured. Participants felt that it was important that the objectives of school health be explained to the personal physician and suggested that this might be accomplished through discussion in county medical society meetings and through articles in society bulletins.

It was generally agreed that county medical societies should organize a program of physical examinations by private physicians. The suggested program would include use of a written form, worked out locally; examination of the children entering kindergarten, and possibly the sixth and ninth grades; a more detailed examination for children participating in competitive athletics; and cooperation between medical societies and doctors in offering reduced rates for preschool examination. It was also suggested that the county medical society be the liaison between doctor and health department. The following specific recommendations were made by this group:

1. That a health examination, including chest x-ray and pertinent laboratory work, of both certificated and noncertificated personnel of schools in California be required and that it be set up periodically during the term of employment, regardless of tenure status.

2. That the appropriate authorities be requested to remove the requirements of two years' experience from the physicians' and dentists' health and development credential.

3. That immunization and physician examinations be divorced from the schools and put back in the doctor's office.

4. That it be recommended to the California Medical Association and the public health profession of the State of California that preventive services be developed in general hospitals for the purpose of providing these services to the indigent part of the population and for the purpose of training young physicians.

5. That dental departments be established in county hospitals, and that these departments be used exclusively for preventive dentistry and the treatment of dental caries for preschool and school-age children.

6. That there be formed in each county medical society a school health committee, composed of physicians, that will work with other interested persons in solving the problems of the school health programs; and that the California Medical Association have a permanent staff person qualified in school health to assist such communities.

7. Due to the time element, it was felt that numerous items of mutual interest failed to be taken into consideration. Therefore, it is recommended that similar conferences be held in the near future on a regional basis.

Group VII—School Physician and School Health

In discussing the role of the school physician, Group VII considered various aspects of the entire school health program and agreed that this program is concerned with maintenance and promotion of the total health of the child in the broadest sense. The discussion which took place is summarized in the group's recommendation which follows:

1. The school health program should be concerned with maintenance and promotion of the total health of the child in the broadest sense.

2. The school physician has a responsibility to interpret the health problems of school children to parents, teachers, nurses, and others.

3. The school physician should participate in curriculum development wherever medical advice is indicated or needed, as well as serving as supervisor on emergencies and illnesses when policies or standing orders are developed.

4. The school physician has an in-service educational role in helping teachers, nurses, and other health personnel to develop insight and understanding of the health needs of the children.

5. The school physician should assume responsibility for community leadership in stimulating the development of health resources, to meet the needs of children, where these do not exist.

6. The school physician should assume leadership in integrating school and community activities.

7. The school physician should participate on, or stimulate the formation of, community school health councils and identify himself with voluntary health agencies.

8. The school physician should provide liaison between the schools and the county medical society and private physicians.

9. The school physician should serve as medical supervisor of the athletic programs and of school health environment.

10. The school physician has an important role in interpreting the multiplicity of forms and slips sent by the school to private physicians.

11. The school physician should serve as counselor or consultant to the school faculty.

12. Physical examinations, from time to time, are desirable. An examination of a child should do more than find defects; it should provide an opportunity for counseling, guidance, and an appraisal of the child's growth, development, and personality.

13. There should be a study at state and local levels on problems relating to children who are without adequate health supervision.

Group VIII—Emergency Care

For the purpose of discussion, members of Group VIII agreed that "emergency care" is the immediate care, such as first aid or exclusion, that is necessitated by accident or illness. This care should be provided in accordance with policies prescribed by school authorities pending assumption of control by parents and treatment by the personal physician, dentist, or other health advisors. Participants stressed the need for each school to have, *in writing*, standard orders and a complete statement of policies to be followed in emergency care. This should be developed by the school administrator, the teacher, the nurse, school physician or county health officer, lay citizens, and representatives of the medical and dental associations. The group stressed that final policies must have medical approval.

Members of the group agreed that in order to give the security which school employees need in order to provide adequate emergency care, governing boards of school districts should obtain blanket liability insurance for all district employees.

Members of the group recommended the following principles for reducing the need for emergency care:

1. There should be a periodic inspection of the entire school plant by qualified people, such as safety engineers, fire and safety insurance personnel, and members of the safety and health committee of the local health council; and also by pupils, parents, teachers, etc.

2. The health and safety curricula of the school must include areas of instruction related to prevention of accidents. Accidents are made, they don't just happen.

3. Teachers should be encouraged to use accident records and reports, accident surveys and other pertinent local information as the basis for classroom instruction in accident prevention.

4. School personnel should give special identification to health cards of individuals who have chronic illnesses to the degree that emergency care may be necessary at some time. Where health records are not immediately available, school authorities should be sure that certain basic health facts are ascertained from parents. The responsibility of parents in this area is paramount.

Group VIII also made the following general recommendations:

1. Accidents, no matter how minor, must have adequate reporting to the proper authority in the school and to the home.

2. A manual of directions for emergency care should be prepared. Listing symptoms rather than disease itself is more useful to the teacher.

3. Each school should have standard orders, in writing, and a complete statement of policies to be followed in emergency care. These policies should include a definite reference to first aid supplies. The orders should be duplicated and placed in the hands of every teacher and be in evidence in the first aid cabinet.

4. That the California Medical Association recommend to the Joint Committee of the State Department of Public Health and the State Department of Education the formulation of guides for the suggested development of local health policies and standing orders to be followed when emergency care is necessary.

5. If possible, teachers and athletic coaches be thoroughly trained in first aid.

6. That there is a grave need to orient and refresh all teachers in emergency care needs.

7. That local administrators promote first aid training by giving points or credits toward salary increments.

8. That teachers should know the state educational code requirements regarding field trips and excursions.

9. That the school secretary or clerk *should not be delegated* to do first aid unless she has had training in emergency care.

10. That governing boards of school districts obtain a blanket liability insurance policy for all district employees.

11. When emergency care has been rendered, the sick or injured child's parents or guardian *should* be notified at once.

12. The committee closed its work with a final recommendation that (1) because of need for emphasis on study of the total health program, services, instruction, and environment, and (2) because the school principal and/or superintendent is the key person in carrying out of a total school health program, we request the California Medical Association to ask Dr. Roy E. Simpson, Superintendent of Public Instruction of the State of California, to request the California Association of Secondary School Principals, and the California Association of Elementary School Principals to make "The School Health Program" the theme of their annual conference in the school year, 1954-1955.

SUMMARY

In general, participants felt that the first California Conference on Physicians and Schools, was successful in stimulating the coordination of efforts of educators, public health personnel, and members of the medical profession toward improving the health protection of California's school children. As one school superintendent said, "At least we are getting some action, not just talking to ourselves about the importance of the school health program."

The importance of teamwork among all persons concerned with the health of the school child was stressed in each discussion group. In reference to this teamwork, emphasis was placed on the need for better interpretation of the school health program and the need for improved channels of communication between school, parent, private physician and dentist and community agencies.

One of the recommendations of the conference as a whole was that similar conferences be held on a regional level where educators, physicians, and public health personnel could cooperate on the improvement of local health programs for the school age child. The California Medical Association is

planning to sponsor nine such meetings between September, 1955 and May 1956.

The tone of the conference was well expressed in the words of one of the participants, who said, "A good school health program, including adequate health services, functional health teaching, and safe and healthful living conditions will do more than improve the health of school children. It will provide the foundation for healthier men and women and a healthier nation in the years to come."

Statement on Oxygen Administration

With Reference to Retrolental Fibroplasia

(The following statement was made by the Advisory Committee on RLF, to the California State Department of Public Health, June, 1955.)

EVIDENCE for a causal relationship between oxygen therapy and retrolental fibroplasia (RLF) now appears to be beyond reasonable doubt. Moreover, the available data indicate that limitation of oxygen treatment does not increase neonatal mortality. Infants weighing 2,000 gms. or less appear to be more susceptible to this syndrome. The incidence of retrolental fibroplasia appears to increase with each additional day of exposure to oxygen during the first seven to ten days of life.

It is strongly urged that the following policies with respect to oxygen administration be adopted at once by all hospitals caring for the newborn:

1. Oxygen should be administered to premature infants only on the specific order of a physician.

2. Oxygen should not be administered in concentrations exceeding 40 per cent, and should be discontinued as soon as the infant's condition permits. Cyanosis and respiratory distress may occasionally require oxygen concentrations exceeding 40 per cent for short periods of time.

3. The prescription for continued oxygen therapy should be renewed daily by the physician.

4. The actual concentration of oxygen during administration should be checked with an oxygen analyzer at least every eight hours.

5. When oxygen is administered for periods longer than three days, the oxygen concentration should be measured more frequently to be sure that it never exceeds 40 per cent.

6. The continuous administration of oxygen for periods in excess of three days should be prescribed only in exceptional circumstances.

The number of children reported as of August 1954 by the field staff of the California School for the Blind and the Variety Club shows a marked increase in the number of cases of retrolental fibroplasia between 1946 and 1952. Although data for 1953 and 1954 were incomplete, 77 per cent of the total known cases of blindness in preschool children in California between 1942 and 1954 were due to RLF.

Information on prevention of retrolental fibroplasia has been widely circulated in professional journals. However, the National Society for Prevention of Blindness recently reported that a considerable number of hospitals had not yet taken definite action to minimize this threat of visual damage.

Two oxygen analyzers for hospital use can be purchased in California:

1. Beckman: Manufactured by Arnold Beckman, Inc., 1020 Mission Street, South Pasadena. Cost approximately $200.

2. Mira: Manufactured by Medical Instrument Research Associates, 2656 W. Pasadena Avenue, Pasadena. Cost approximately $150.

Until such time as an oxygen analyzer can be purchased, it is recommended that a flow of not more than 2 liters per minute be permitted in the open-lid type incubator, and from 1 to 2 liters per minute in the porthole type. (Complete instructions for the maintenance of oxygen concentration in the Isolette have recently been mailed by the manufacturers to all hospitals owning these incubators. These instructions should be kept in the nursery and followed closely.)

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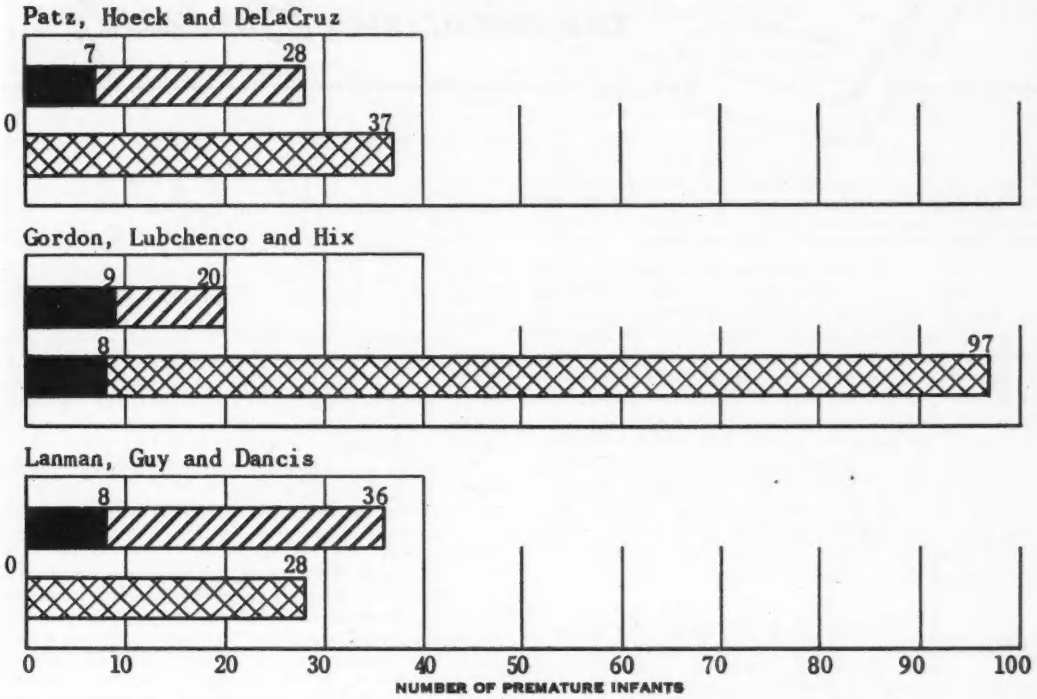
EFFECT OF OXYGEN ON RETROLENTAL FIBROPLASIA

Adapted from Figure in SCOPE, Vol. IV, No. 3, Fall, 1954

RESULTS IN THREE INVESTIGATIVE STUDIES



Number of premature infants in high oxygen (over 60%)

Number of premature infants in minimal oxygen (under 40%)

Number of premature infants showing evidence of retrolental fibroplasia at 3 months of age

All infants in the first two series had birth weights to 1500 gm. (3.3 lbs.), in the third series from 1000 to 1850 gm. (2.2 to 4.1 lbs.). Criteria for evidence of retrolental fibroplasia were as follows: Top—retinal detachment (5 to 7 had membranes); Center—any detectable permanent change, in minimal oxygen group only 2 of 8 had retrolental membranes; in high oxygen, 7 of 9 had membranes; Bottom—irreversible cicatricial lesions (membranes).

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7. The control of oxygen therapy for the prevention of retrolental fibroplasia (editorial), J. Pediat., 46:3, March 1955.

THE PHYSICIAN'S *Bookshelf*

THE ADOLESCENT EXCEPTIONAL CHILD—A Realistic Approach to Treatment and Training. Proceedings of the 1954 Spring Conference of the Child Research Clinic of the Woods Schools, Langhorne, Pennsylvania.

This 78-page pamphlet constitutes the proceedings at the third Conference on the Exceptional Child to be held under the auspices of The Woods Schools for Exceptional Children. The other two conferences took place in 1950 and 1953 and dealt with the Exceptional Child in Infancy and Early Childhood, and the Exceptional Child in the Preadolescent Years, respectively. All conference proceedings, including this pamphlet, are available free of charge upon request to The Woods Schools at Langhorne, Pennsylvania.

This, the most recent of these conferences, deals with the diagnosis, treatment, training and, particularly, the occupational placement of the retarded adolescent. The discussion by the representative panel will be of interest to educators, physicians, parents, and all others concerned with the handling and guidance of retarded children.

* * *

HANDBOOK OF RADIOLOGY. Russell H. Morgan, M.D., Professor of Radiology, Johns Hopkins University Medical School, Editor; and Kenneth E. Corrigan, Ph.D., Associate Professor of Radiology, Wayne University, Associate Editor. The Year Book Publishers, Inc., 200 East Illinois, Chicago, 1955. 518 pages, $10.00.

This book is one that should find its way to the working library of every radiologist, every doctor working with ionizing radiations, and scientists working with radioisotopes, either naturally or artificially produced. The book is well conceived and the material in it well presented. The content of the handbook is best presented by giving the titles of its sections.

Section 1. Definitions of Physical Terms and Units (including Conversion Formulæ and Tables).

Section 2. General Physical Information (including Biophysical Data).

Section 3. Radiotherapeutic Data.

Section 4. Radioisotopes.

Section 5. Radiography and Fluoroscopy.

Section 6. Radiation Protection.

Appendix A. Common Drugs Used in Radiology.

Appendix B. Mathematical Tables.

Appendix C. The Greek Alphabet.

Appendix D. Schematic Diagrams of X-ray Generators and Particle Accelerators.

Section 1 presents a very large number of definitions not easily found in the working library of most physicians. The subsection on ionizing and light radiation gives definitions frequently needed by practicing and experimental radiologists.

Section 2 gives a great deal of information similar to that found in the handbook of chemistry and physics on the various atoms in the periodic table as well as data on the interaction of these with various radiations.

Section 3 gives mainly information on depth doses for all kinds of radiations.

The section on radioisotopes gives the decay characteristics of frequently-used isotopes and data on secondary radiation standards.

The section on characteristics of medical materials gives information on various developing solutions, characteristics of films, speed ratings of various film developer combinations, spectral distributions of light from various fluorescent screens, sensitivity of screens, and comparative data on various x-ray tubes.

The section on contrast media gives fairly complete up-to-date data on all contrast media.

The section on radiographic technique includes drawings of patient position as well as standard exposure techniques for all parts.

The section on radiation protection gives both the lead and concrete thickness required for adequate protection. It gives sensitivity ranges for photographic material used in radiation monitoring. It gives most useful data on the doses of radiation used in diagnostic radiographic procedures.

The editors and their collaborators should be congratulated on bringing out a most timely volume.

* * *

ADVANCES IN PEDIATRICS—Vol. VII, 1925. S. Z. Levine, Cornell University Medical College, Editor. The Year Book Publishers, Inc., 200 East Illinois, Chicago, 1955. 351 pages, $8.00.

This volume contains seven monographs of which possibly only three could be called "Advances in Pediatrics." Others are mostly extensive reviews of already well established pediatric knowledge and practices.

1. *On Fibrous Defects in Cortical Walls of Growing Tubular Bones*, John Caffey, Columbia University and Babies Hospital, New York. This monograph covers an x-ray study of 1,000 children. There are 16 pages of excellent radiographic plates. The structure of the lesions is discussed. The prevalence in normal children is considered as normal variants of growth. Differential diagnosis is discussed at length. Eighteen references.

2. *The Urinary Tract in Childhood.* Meredith F. Campbell, Miami, Fla. This is an encyclopedia of the urinary tract in children covering embryology, urinary obstruction, anomalies, infections, neuromuscular uropathy, tumors, calculi, injuries, symptoms, diagnosis and treatment. Nothing new is covered. A good review of all conditions relating to the urinary tract in children gathered from personal experience. Numerous tables and figures. Nine pages of x-ray reproductions. No references.

3. *Malnutrition in Infancy and Childhood with Special Reference to Kwashiorkor.* Frederico Gomez, Rafeal Ramos Galvan, Joaquin Cravioto, Silvestore Frenk, Hospital Infan-

til de Mexico, Mexico, D. F., Mexico. Etiology is largely economic, long continued under feeding, or failure to utilize proper foods, especially proteins. Three types are considered depending upon the degree of underweight. Pathological effect upon the various tissues and organs is discussed. Severe or third degree type is the same as the African Kwashiorkor. Treatment is outlined with poor prognosis in the third degree classification. One hundred twenty-nine references.

4. *Phonocardiography in Children.* Edgar Mannheimer, Caroline Hospital, Stockholm. Phonocardiography is recording the vibrations of the thoracic wall caused by the sound phenomena of the heart. Its value lies in giving information concerning sounds and murmurs and different types of gallop which cannot be heard by auscultation. Process demands reproducibility. He outlines fundamental acoustic principles and methods which involve a good knowledge of electronics. The phonocardiogram of normal children is described as well as the murmurs and sounds of congenital heart conditions, acute rheumatic fever and acute carditis. Seventeen plates, one of the apparatus and 16 of the various cardiac conditions. Seventy-three references.

5. *Infantile Cerebral Palsy.* Meyer A. Perlstein, Chicago. An excellent treatise covering incidence, etiology and pathogenesis with precipitating factors. Classification and clinical types are outstanding parts of the monograph. Cerebral palsy is incurable but he outlines the degree of mental and physical development expected. Drugs are of little value in treatment. Best result in treatment is by a team composed of most of the branches of medical practice. Five pages of unnumbered references.

6. *Mucoviscidosis.* Harry Shwachman, Hugo Leubner, Children's Medical Center, Harvard Medical School, Boston. A lengthy discourse. Since the disease is not primarily a disease of the pancreas but of an increased viscosity of fluids from secreting glands older nomenclature should be discarded. The incidence, classification, differential diagnosis and clinical picture are discussed at length. Methods and techniques of diagnosis are given. An outline of treatment is given for this ultimately fatal disease. One hundred forty-two references.

7. *Congenital Megacolon.* Oscar Swenson, Boston Floating Hospital and Tuft's Medical College, Boston. Diagnostic criteria are outlined for diagnosis of Hirshsprung's disease. Study of the urinary tract is advised for often there is atony of bladder and ureters associated. Differential diagnosis between ileal obstruction in the newborn and congenital Hirshsprung's disease is discussed. Limited operative technique is outlined which is life saving for these patients. The monograph is based on 139 operated cases. Twelve references.

* * *

THE ECZEMAS—A Symposium by Ten Authors. L. J. A. Loewenthal, M.D., M.R.C.P., D.T.M. and H., Lecturer in Dermatology, University of Witwatersrand, formerly Honorary Assistant Dermatologist, Hospital for Cancer and Skin Diseases, Liverpool. E. & S. Livingstone, Ltd., Edinburgh, distributed by Williams and Wilkins, Baltimore, 1954. 267 pages, $7.50.

The Eczemas is a symposium by ten authors who are well known authorities in dermatologic circles. Among the contributors to this concisely written book are Sulzberger, Haxthausen and Peterkin. There are 13 chapters which take up subjects such as contact eczema, allergic eczema, atopic dermatitis, the role of bacteria in eczema and so forth. The chapter on General Principles of Treatment in Eczema is sound and contains a good bit of practical advice. A useful formulary and a table of concentrations of vehicles to be used in patch testing is found in the appendix.

HANDBOOK OF TROPICAL DERMATOLOGY AND MEDICAL MYCOLOGY—Vols. I and II. Edited by R. D. G. Ph. Simons, Senior Lecturer at the Dermatologic University of Leyden and Dermatologist-in-charge at the Civilian Hospital, Amsterdam. Elsevier Publishing Company, 402 Lovett Blvd., Houston, 300 Park Ave., New York, 1952-53. 1745 pages, $15.00 per volume.

All skin diseases likely to be seen in tropical areas throughout the world are discussed in this large, two-volume work. Although over 90 contributors from all parts of the world have written chapters, the book is well organized in a surprisingly uniform style. Contributors from California include Paul Fasal on "Cutaneous Leishmaniasis" and "American Leishmaniasis," "North American Blastomycosis" and "Cutaneous Tuberculosis" and "Sarcoidosis"; Dr. Francis Keddie on "The Rickettsioses"; Dr. Frederick G. Novy on "Tropical Acne"; Drs. Maximilian E. Obermayer and G. Walter Wilson on "Disorders Caused by Animal Organisms"; Drs. J. Walter Wilson and Orda A. Plunkett on "Introductory Notes on the Term 'Blastomycosis'"; Dr. Robert A. Stewart on "Coccidioidomycosis."

Most of the chapters discuss particular diseases in a manner which facilitates easy reference; treatments suggested are up to date. Information is included on many dermatological disorders not confined to tropical areas such as vitiligo, chloasma, cutaneous syphilis, cutaneous syphilis and sarcoidosis; lymphopathia venerea, miliaria, scabies, oxyuria, allergy and the "id" concept and benign and malignant skin tumors. In the sections on Diseases Due to Fungi, there is a general discussion on Mycology followed by descriptions of the various superficial and deep mycoses. Many interesting and sometimes amusing facts of the history of dermatologic disease and terminology are revealed in the introductory chapters and addendum.

* * *

THE SKIN—A Clinicopathologic Treatise. Arthur C. Allen, M.D., Associate Pathologist, Memorial Hospital, Associate Professor of Pathology, Cornell University Medical School, New York. The C. V. Mosby Company, St. Louis, 1954. 1048 pages, 495 full page illustrations, $25.00.

The Skin is a clinicopathologic treatise by Arthur C. Allen, pathologist to the Memorial Hospital of New York City. This book represents an outstanding contribution. It encompasses 495 full-page illustrations and over 1,000 pages of text. The value of this book lies in the correlation of the clinical and microscopic pictures of almost every disease which affects the skin.

Of the 28 chapters in this text, Chapter 24 on nevi and malignant melanomas is the most outstanding. It incorporates information which is of interest to students of cancer, surgeons, dermatologists, radiologists and pediatricians.

This text is to be recommended as an outstanding contribution to the medical literature.

* * *

CARDIAC EMERGENCIES AND HEART FAILURE—Prevention and Treatment, Second Edition. Arthur M. Master, M.D., Cardiologist, Mount Sinai Hospital, N. Y., Associate Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia; Marvin Moser, M.D., Assistant Physician in Medicine, Montefiore Hospital; and Harry L. Jaffe, M.D., Assistant Attending Physician, Cardiology, Mount Sinai Hospital, New York. Lea & Febiger, Philadelphia, 1955. 263 pages, $3.75.

This compact book includes an astonishing amount of practical information on the therapy of various cardiovascular emergencies. It is divided into 9 chapters covering the arrhythmias, acute heart failure, coronary artery disease, syncope, rheumatic heart disease, hypertensive states, dissecting aneurysm, traumatic heart lesions, and

surgery in heart disease. As such it covers the great majority of common conditions in which emergencies occur. Mention is not made, but would seem useful, of shock other than in myocardial infarction and of cardiovascular complications of pregnancy and labor. The presentation of details of drug administration and other therapy is succinct and current. This is noteworthy in digitalis intoxication, arrhythmias and myocardial infarction.

Short case histories enliven the presentations of results of therapy and the brief comments on the pathologic physiology and clinical patterns give reason for the therapy presented for various conditions.

The attempt to differentiate acute coronary insufficiency from other mild forms of myocardial infarction has not met with the universal acceptance warranting such separation, in this discussion of therapy.

As may be expected, there are certain subjects in which differences of opinion would arise as to relative importance of techniques and dangers of certain procedures. A few examples are:

1. Tent, rather than nasal cannulae or mask, administration of oxygen and the omission of the use of the Bennett positive pressure oxygen apparatus.

2. The assumed restriction of L-norepinephrine concentration to 4 mg. per liter in intravenous therapy for shock and inadequate details of the technique of administration.

3. The failure to define the duration, preferably 0.1 sec., of the high voltage electric shock for cardiac defibrillation.

This book is not merely a compendium of drugs and techniques, but rather an excellent critical appraisal of relative values of procedures according to the authors' broad experience and the consensus of published reports. From the astute introduction of what should be available in the physician's bag, to the adequate bibliography and index, this monograph should be a valuable part of the working equipment of the active medical practitioner. Students will find it contains much authentic information clearly and briefly presented.

* * *

PRIMARY ANATOMY. H. A. Cates, M.B., Late Professor of Anatomy, University of Toronto, and J. V. Basmajian, M.D., Associate Professor of Anatomy, University of Toronto. The Williams and Wilkins Company, Baltimore, 1955. 339 pages, $5.75.

This is a very small-sized book on anatomy which is written particularly for the ancillary medical fields which require a knowledge of anatomy. As a result, it is very straightforward, simple, direct, with clear and concise diagrammatic illustrations. It serves a very useful purpose in this particular area but is a book which would hardly be of value for either the medical student or for the practicing physician. Its main field of usefulness will be for the physiotherapist, occupational therapist, students in physical and health education. It will also be an excellent book for nurses and for the latter groups of people it can be strongly recommended. This is not an anatomy book for medical students or physicians.

* * *

SHEARER'S MANUAL OF HUMAN DISSECTION—3rd ed. Edited by Charles E. Tobin, Ph.D., Associate Professor of Anatomy, University of Rochester School of Medicine and Dentistry. McGraw-Hill Book Company, Inc., 1955. 287 pages, $6.00.

With the recent trends to try and condense the amount of anatomy teaching in medical schools, one sees appearing on the market more and more, shorter textbooks of anatomy and shorter dissection manuals in the field of anatomy.

The effort of Charles E. Tobin in his revision of *Shearer's Manual of Human Dissection* has resulted in a book with this particular concept of the role of anatomy in medical school teaching in mind. The book is brief, concise and to the point. The illustrations in it are few, diagrammatic but clear and rather well done. The book could certainly not serve as a primary text in anatomy nor could it be used alone as a dissection manual in the field. However, it would serve a nice purpose for one who wishes to rapidly review the field of anatomy during the course of his student days or in his later years. In this regard it might be worth while to mention the fact that for the postgraduate physician a more ready review of anatomy can be obtained in the illustrated type of book which has recently been published by Bassett of Stanford University, but a book which is far more expensive. Nevertheless, an approach of the latter type makes anatomy a much more significant and live subject for the practicing physician or surgeon and also serves excellently for students.

If one is looking for a small inexpensive book on human dissection the book by Dr. Tobin is well done. On the other hand it is not equal to the standard textbooks of anatomy and does not afford the simplicity of the extensive visual aid types of books which have been referred to above. The approach is not from the surgical standpoint so it would be of relatively little value for the operating surgeon.

* * *

DISEASES OF THE SKIN—8th ed., thoroughly revised. Oliver S. Ormsby, M.D., Late Rush Professor of Dermatology, University of Illinois; and Hamilton Montgomery, M.D., M.S., Professor of Dermatology and Syphilology, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minn. Lea & Febiger, Philadelphia, 1954. 1503 pages, 666 figures containing 750 illustrations and 18 colored illustrations on 11 plates, $22.00.

The eighth edition of Ormsby and Montgomery's *Diseases of the Skin* contains numerous improvements over the previous edition. DeLamater, Professor of Dermatology at the University of Pennsylvania, has brought his section on mycologic disorders up to date; Lobitz of Dartmouth has contributed a chapter on the physiology and chemistry of the skin. This represents the finest chapter of its kind in any dermatologic text. Kierland and Farber have contributed chapters on syphilis and peripheral vascular diseases respectively.

More information is available on the classification and treatment of pemphigus, and excellent information is available on the classification of lupus erythematosus and the identification of the L. E. cell.

This book is to be recommended to specialists in dermatology and pathologists.

* * *

POMP AND PESTILENCE—Infectious Disease, Its Origins and Conquest. Ronald Hare, M.D., Professor of Bacteriology in the University of London and at St. Thomas's Hospital Medical School. The Philosophical Library, Inc., New York, 1955. 224 pages, $5.75.

This readable little book deals with infections from a general standpoint; it is, however, richly documented with so many specific examples that one has no feeling of vacuity. The reader may gather an idea of what is in the book by scanning the table of contents—Parasites and Parasitism, Man and His Parasites, Parasites and Pestilence, Miasmas or Microbes and finally the Reaction of the Community and of the Individual and Parasites and Populations. There are chapter notes with references to the literature and there is an index. To show how quickly things move, in the group of parasites over whose effect we have no control poliomyelitis is still mentioned!

AMPUTATIONS. Leon Gillis, M.B.E., M.B., B.Ch.(Witwatersrand), M.Ch.Orth.(Liverpool), D.L.O.(London), F.R.C.S.(England), F.R.C.S.(Edinburgh), Hon. F.I.C.S.(Geneva). Grune & Stratton, New York, 1954. 423 pages, $12.75.

This monograph, *Amputations*, is a comprehensive textbook containing invaluable material pinpointing the guiding principles and modern techniques. Particular discussion concerning obsolete operative procedures heretofore perpetuated in general surgery texts is one of the main themes running through the entire presentation. The methods to prevent these older common errors are interwoven throughout the text with definitely organized planning.

Each of the twenty chapters of the book of more than 400 pages is clearly written to direct purposeful surgical action in conditions requiring amputation, not only in accordance with time-tested principles, but also to explain advances made possible by more recent surgical experience and rehabilitation with mechanically improved prostheses.

A successful method of neo-arthrosis of the shaft of the humerus is an example of one of these advances; others include more practical schemes to enlist residual function in upper extremity amputation stumps by plastic reconstruction. Much of the contrary teaching of the past, little more than mummery of ancient dicta, is corrected by ample logical discussion.

The numerous clear illustrations are unusually pertinent, serving as extremely valuable visual stimulants to further exploration and study of the text.

* * *

DEMONSTRATIONS OF PHYSICAL SIGNS IN CLINICAL SURGERY—12th ed. Hamilton Bailey, F.R.C.S.(Eng.), F.A.C.S., F.R.S.E., Emeritus Surgeon, Royal Northern Hospital, London. Assisted by Allan Clain, M.B.(Cape Town), F.R.C.S.(Eng.), Senior Surgical Registrar, Royal Cancer Hospital, London. The Williams and Wilkins Company, Baltimore, 1954. 456 pages, $8.00.

The art of a physical examination is rapidly becoming a lost art in these days of highly specialized techniques and the application of biophysical instruments to the study of clinical pathological, physiological states. Nevertheless, there is a great need for a simple, clear book on the physical signs of clinical surgery and the book by Bailey serves this purpose admirably.

The majority of surgical disorders are still diagnosed essentially by inspection and palpation, percussion and auscultation and this book is a masterpiece of presentation of the physical signs of clinical surgery.

It can be strongly recommended to medical students and to the practicing physician who is interested in sharpening his diagnostic acumen from proper interpretation, understanding of physical signs and clinical surgery. It is the best book in its field in this area and it can be strongly recommended.

* * *

NEUROLOGY—3 vols.—2nd ed. S. A. Kinnier Wilson, M.A., M.D., D.Sc.(Edin.), F.R.C.P., formerly Physician, National Hospital, Queen Square; Senior Neurologist, King's College Hospital. Edited by A. Ninian Bruce, F.R.C.P.(Edin.), D.Sc.(Edin.), M.D., F.R.S.(Edin.), Lt.-Col. R.A.M.C., Consulting Physician, Bangour Mental Hospital and St. Andrew's Hospital, Hawick. The Williams and Wilkins Company, Baltimore, 1955. 2060 pages, plus 99 pages of index, $37.50.

It will soon be twenty years since the death of Kinnier Wilson. His textbook of neurology was unfinished at his death, and the task of getting the material in shape for publication was undertaken ably by Dr. Bruce, who has now brought out a second edition of the work. In the second edition are included a chapter on Aphasia, Apraxia, and Agnosia by Sir Russell Brain, thus making up this deficit of the original text, as well as a bringing up-to-date of the portion dealing with the treatment of neurosyphilis which has changed so markedly in the interval. Other additions have been made to encompass modern progress in the subject, but without changing the greatest asset the book possesses, which is Wilson's clear and polished mode of expression. In all, the necessary changes have resulted in a book which will continue to hold its place as preeminent among textbooks of neurology in the English language. It is now contained in three volumes of about 600 pages of text each, and forms the best reference work on the subject with which the reviewer has come in contact. Although it cannot attain the encyclopedic coverage of compendia written by many experts in the various fields, it has the great advantage of presenting one man's critical evaluation of the whole field of neurology, and for this reason is highly recommended.

* * *

A TEXTBOOK OF PHYSIOLOGY—17th Edition. Edited by John F. Fulton, M.D., Sterling Professor of the History of Medicine, Yale University School of Medicine. W. B. Saunders, Philadelphia, 1955. 1275 pages, 600 illustrations, $13.50.

Five years have elapsed since the previous edition of this book; by this time there is little material recognizable as remaining from the fifty-year-old Howell. This volume represents the combined efforts of thirty contributors and the editor, each of whom has excellent command of his respective field. It is an advanced, detailed and generally up-to-date textbook. For the beginning medical student it represents heavy going and is definitely not in the category of a quick and handy survey of the field of physiology. Of the available advanced modern textbooks, it should be awarded first place as a sound reference work, but the practicing doctor will not find physiological principles neatly tied to clinical problems, as is the case with one of the major English textbooks of physiology and another from the Canadian group. For those in search of a quick review to prepare for state or national board examinations, Fulton will be useful chiefly to those whose background in physiology is relatively complete and recent. For the more advanced graduate preparing for specialty boards this text should serve an extremely useful purpose for topical reference.

This book divides the topics into twelve sections. The first four deal with the physiology of nerve, muscle and the central nervous system; blood, circulation, and respiration occupy the next three sections. One section is devoted to each of the following: body fluids and kidney functions; digestion; metabolism and nutrition; endocrine system; and the physiology of reproduction. By far the largest group of sections in the text concern the special field of the editor and reflect his preoccupation with this aspect of physiology. In the opinion of the reviewer the text is overburdened with nervous system physiology, although it is extremely well done. The organization of the book suffers somewhat from too rigid adherence to the traditional division of material by systems, a pattern to some extent enforced by multiple authorship of the various chapters and sections.

Portions of the book rewritten since the sixteenth edition include the first seven chapters covering nervous system and muscle. It is gratifying to note that muscle physiology has come of age. The stultifying preoccupation with twitching frog muscle has given way to an interesting combination of functional and metabolic aspects of muscle physiology, up-to-date and clearly related to medical problems. The chapters on Body Fluids and Kidney Function

have been rewritten for the seventeenth edition. Dr. William Blake's discussion of kidney function is particularly well handled. It is clear, critical and up-to-date, with the best analysis of current evidence on renal management of water and electrolyte that has come to this reviewer's attention. The companion chapter on Body Fluids by Dr. Raul Hernandez-Peon, except for some minor errors (see Table 27) is well presented. Although this chapter seems superior to those on the same topics in other major texts, it makes not quite adequate use of the more recent literature, and it is written with less critical skill and helpful analysis of evidence than that on kidney function.

Many cardiologists will probably take sharp issue with the point of view expressed in Nahum's presentation of the material on electrocardiography. The dipole theory dies hard. In this controversial field it is gratifying and refreshing to recognize in his critical discussions a strong attempt to base electrocardiography upon sound biophysical data in contrast to slower and often erroneous interpretation derived from empirical correlation of curves with pathological data.

The section on respiration comprising four chapters presents a curious mixture: a relatively pedestrian discussion of the anatomy and physics of respiration and blood gas transport, and an excellent modern, up-to-date discussion of the neurogenesis and regulation of respiration. It is unfortunate that there is no presentation of the physiological basis for modern tests of pulmonary function, including gas dilution methods for total pulmonary volume and those measuring maximum breathing capacity and respiratory reserve.

Probably an accident of timing prevented the most recent and exciting advances in the field of endocrinology from being included in the last two chapters of this text. No author should be envied the task of winnowing the enormous literature in endocrinology for material to be compressed within the necessary page limitations. The material has been well selected and competently handled.

Whether this book should be upon the general doctor's shelf is a question largely determined by the nature of his practice, his interests and his book budget. In the reviewer's opinion as a reference work it is superior to other advanced textbooks currently available in this field.

* * *

GROVES' SYNOPSIS OF SURGERY—14th ed. Edited by Sir Cecil Wakeley, Bt., K.B.E., C.B., LL.D., M.Ch., D.Sc., F.R.C.S., F.R.S.E., F.A.C.S., F.R.A.C.S. The Williams and Wilkins Company, Baltimore, 1954. 651 pages, $7.00.

The English surgeons have a knack of putting down in carefully outlined sequential form the essential facts of clinical surgery on which future foundations of knowledge can be built. The book by Groves entitled *Synopsis of Surgery* is another excellent book meeting this purpose.

For one who wants a rapid quick summary of the essentials of the field it serves admirably well. It would be particularly good for students as an introduction to surgery. It will be less valuable as a book for the practicing physician, once he has learned the fundamentals of the field. It would also be a good review book for students and for physicians preparing for a State Board examination. This book is not great but it is clear, practical and to the point. It is inexpensive, diagrammatic and clear and can be recommended as a review book in surgery or as an introductory book to surgery, but certainly not as a text to surgery or one giving the information which will enable one to treat specific illnesses in the surgical field.

UROLOGY—Vols. I, II and III. Edited by Meredith Campbell, M.S., M.D., F.A.C.S., Emeritus Professor of Urology, New York University; with the collaboration of 51 contributing authorities. W. B. Saunders Company, Philadelphia, 1954. 2356 pages, plus 64 pages of index and 1,148 figures, $60.00 per set.

Keeping pace with the recent mushrooming growth and adaptive of emphasis in urology, Campbell's new, three-volume text adequately fills the current need for a comprehensive reference text in the English language. Written by 52 authors, predominantly American urologists, the work is a compendium of monographs by leaders in their respective fields. Appropriate consideration has been given to new frontiers in physiology, electrolyte balance, biochemistry and endocrinology, applied to urology. Approximately one-fifth of the subject matter is devoted to an excellent section on urologic surgery, abundantly illustrated and incorporating the most recent operative techniques. The material presented in eighteen sections is well planned, progressing from anatomy and physiology to a systematic consideration of urologic disorders, special attention is given the problems of infertility in the male, neuromuscular diseases of the urinary tract, urologic disorders in the female and in the child. Later sections are devoted to endocrinology, urologic surgery with pre- and postoperative care, brief mention of radiation therapy, a discussion of medical diseases of the kidney and a final chapter on the adrenals.

Doctor Campbell is to be congratulated for his exhaustive sections on congenital anomalies and the diseases of infancy and childhood condensed from Campbell's Clinical Pediatric Urology, another of Saunders' impressive texts.

The index is adequate, and the bibliographies at the end of each section are well proportioned and provide a handy key to the modern literature.

Containing as it does considerable material not elsewhere available, this text should be in the hands of every urologist, general practitioner, internist and pediatrician. While not suitable for the medical student, it should be "must" reading for every urologic resident.

* * *

INTERN'S MANUAL (Cook County Hospital). Arthur Bernstein, M.D., Assistant Medical Superintendent Cook County Hospital, Clinical Associate Professor of Medicine, University of Illinois College of Medicine. The Year Book Publishers, Inc., 200 East Illinois Street, Chicago, 1954. 292 pages, $3.00.

This is a pocket size volume in a paper cover. It attempts to present in outline form the diagnostic features and therapeutic measures applicable to the diseases and injuries commonly seen in a large hospital. The subject matter is presented in alphabetical arrangement with cross references to prevent repetition. There is no index. This is an unfortunate omission, because the three or four pages necessary to include an adequate index would have increased the effectiveness and convenience of the manual. A manual of this size cannot be complete yet there are some obvious omissions in this one that could easily have been corrected. For example, there is no discussion of antibiotics yet there are such statements as "large doses of penicillin are indicated," or "an antibiotic or sulfa drug is indicated." On the other hand a full page is given to the discussion of Zepherin. There is no section on obstetrics and no discussion of gynecological problems.

Most interns feel the need for some means of orientation and maintenance of perspective. An outline such as this will help. For those hospitals lacking their own manual this one should prove quite satisfactory. It could also be used by the visiting and teaching staff as an outline for their instruction and teaching.

Proceedings
of the
House of Delegates

May 1 to 4, 1955

C. M. A. House of Delegates Proceedings

San Francisco, May 1-4, 1955

Sunday Morning Session

The opening session of the 1955 Annual Session of the House of Delegates of the California Medical Association was held in the Ballroom of the Sheraton-Palace Hotel, San Francisco, California, Sunday, May 1, 1955. The meeting was called to order by Speaker Donald A. Charnock, of Los Angeles, California, at 9:30 a.m.

SPEAKER CHARNOCK: Will the 1955 House of Delegates of the California Medical Association please come to order. Will the delegates move up to the tables and will the alternates please sit behind them.

We will have the report of the Committee on Credentials and Organization of the House of Delegates, Dr. Francis P. Wisner.

DR. FRANCIS P. WISNER: A quorum of delegates is present and I move that we accept the visual roll call as an indication of the constitution of the House of Delegates. . . .

. . . The motion was seconded.

SPEAKER CHARNOCK: It has been moved and seconded that we accept the visual roll call as an index of the constitution of the House. Is there any discussion? Those who are in favor will signify by saying "aye." Contrary minded? The House is constituted. . . .

Thank you, Dr. Wisner.

At this time we will announce and ask approval of the Reference Committees.

The Credentials Committee: Francis P. Wisner, Marysville, California, chairman; Donald C. Harrington, Stockton; Matthew N. Hosmer, San Francisco.

Reference Committee No. 1—Reports of Officers, Councilors, Standing and Special Committees: Dave F. Dozier, Sacramento, chairman; Thomas Dozier, Antioch; Roger A. Vargas, San Bernardino.

Reference Committee No. 2—Reports of Secretary-Treasurer and Executive Secretary, Budget and Dues: Thomas P. Hill, Lakeport, chairman; Henry Gibbons, III, San Francisco; Robert J. Moes, Los Angeles.

Reference Committee No. 3 — New Business: Helen B. Weyrauch, San Francisco, chairman; Arthur A. Marlow, La Jolla; Robb Smith, Orange Cove.

Reference Committee No. 4—Amendments to the Constitution and By-Laws: Dorothy M. Allen, Oakland, chairman; James E. Feldmayer, Exeter; Herbert C. Moffitt, Jr., San Francisco.

C.P.S. Reference Committee—C.P.S. Business: Dan O. Kilroy, Sacramento, chairman; Fred A. Olson, Fortuna; Frederick Ewens, Manhattan Beach.

May we have the approval of these reference committees?

. . . It was moved and seconded that the reference committees stand. The motion was put to a vote and carried.

SPEAKER CHARNOCK: Last year we started with a very nice custom of having the President of the Woman's Auxiliary come to address the House of Delegates: The Woman's Auxiliary and the President of the Woman's Auxiliary have been especially commended by the Legislature of the State of California in this beautiful document. It gives me a great deal of pleasure to present to you, the member from the distaff side, the President of the Woman's Auxiliary to the California Medical Association, Mrs. Frederick J. Miller, of Bakersfield.

MRS. FREDERICK J. MILLER, Bakersfield: Thank you, thank you very much, Dr. Charnock. Dr. Morrison, Dr. Shipman, members of the House of Delegates and guests: This morning I feel very much like the little colored boy who fell into the barrel of molasses, who when he looked around and realized what a wonderful predicament he was in, raised his big black eyes and said, "Oh, Lord, give me a tongue equal to my opportunity." I couldn't be more sincere when I tell you if I could pray for just one thing this morning it would be to be more eloquent so that I could do justice to the wonderful opportunity that I have.

Here I am trying to speak for the fifty-nine hundred and seventy-eight — notice that, almost six thousand—members in the Auxiliary in California, and trying to tell you in just ten brief minutes what those fifty-nine hundred and seventy-eight members have accomplished these past twelve months. Obviously that is impossible, and furthermore it is unnecessary.

Now I could make a long and detailed report of it if you were just an ordinary group of ordinary doctors; then you might not know much about the Auxiliary. Of course, you are not an ordinary group, you are the House of Delegates of the California Medical Association and that tells me two very important things about all of you as individuals and as a group. It tells me in the first place that you have a keen interest in your own county medical societies.

The very fact that you took time away from a very busy practice to come here to this convention proves that, and it tells me, too, that you are recog-

ized as one of the leaders in the forming of policies and thinking of that county medical society and your State Medical Association. The very fact that your associates back home have chosen you to be their representatives at this important meeting proves that. Knowing those two important facts about you, your interest in medical affairs and your position as a leader, I can certainly draw this very obvious deduction—if you are that much interested in your own medical society you certainly are aware of and interested in what the Auxiliary is doing, too, because we are your partners and we are the strongest allies you have in the field of public relations.

I imagine that most of you occasionally browse through *Courier,* which is our state magazine, and which is voted annually to be the finest publication of its kind in the United States; it comes into your homes five times a year. You should read it, you know. C.M.A. thought it well worth while. It is a wonderful magazine; it tells you what we are doing throughout the thirty-two counties in California during the year.

We are given probably two pages every month so that we can tell you a little bit about what our Auxiliary is doing on the county, state and national level. I am certain that you keep up with what your home town Auxiliary is doing.

So with all that organization you certainly know what the Auxiliary stands for, what its objectives are and what we have been doing in the twenty-six years we have been organized in the State of California; for that reason this can be a very brief report and not a detailed one.

You certainly know that the Auxiliary, as I say, is your strongest ally, that we are your partners in the field of public relations, and that we have just one purpose in being organized, to help the medical profession. In this way we are not outsiders, we are not subversives; we are your own wives. When we stood up to love, honor and cherish you we also promised to love, honor and cherish your medical profession too, so that we are really your partners, not only in private life but in the Auxiliary.

We are not a militant organization, we are not a pressure group, and you wouldn't want us to be. We would cause you harm and embarrassment if we were, but in our own quiet, ladylike way, through study groups and open health meetings, we can and do exert quite an influence upon the thinking and attitudes of nonmedical friends.

The second thing we are not—we are not primarily a fund-raising organization. Yet every year we raise around sixty to seventy thousand dollars up and down the state in our county auxiliaries, which gives us funds for some very worthwhile projects like the nursery equipment. Every year some sixteen thousand dollars in scholarships are used to arouse increased interest in the young women in nursing as a career. We also worked very hard for the Medical Foundation this year; our check will be somewhat over five thousand dollars and we still have several counties to hear from.

We also worked hard to raise funds for your Physicians' Benevolence Fund and our check will be for three thousand seven hundred and forty dollars. We still have five counties to hear from and it may be a little more.

In these activities it is not the money that is important. We don't think the figures we quoted are very impressive, the little more than five thousand dollars we give to C.M.A. It isn't the money itself that is important, but in raising it we get some very valuable and important by-products. When we work together to raise this money we become better acquainted and when we become better acquainted we become better friends, and friendliness among ourselves is very important. Doctors' families ought to be friendly; the things we have in common and the things that bind us together are more important than the little jealousies that tend to drive us apart. It gives us publicity; we again are written up in the home town paper. Every bit of good publicity goes for the whole medical profession because we are so closely identified with you.

The third by-product is that we ourselves are learning a great deal. We learn why there is a shortage of nurses and why we as doctors' wives must strive to increase their number. We learn a great deal about the Medical Education Foundation; we know what it is, what it does, and know why the medical schools must get their money through donations. The money itself is not the important thing.

I have told you what we are not, not a pressure group, not a fund-raising group; very simply, we are a community service organization. Every year our members give their time, their talents, their money and their energy to making their own communities a better place in which to live and if I were to tell you the wonderful things this Auxiliary has done during the past year, twenty-six years in fact, that would be a much longer speech than you could tolerate. We will sum it up in this one phrase, Community Service. It is what we are organized for, the thing that is always the ultimate goal in everything we do. There again the same by-products prevail, tend to develop, to create good public relations for you.

Can't a doctor's wife perform community service by being an Auxiliary member? Certainly she can; many of them do and we are proud of them. There is this thing about working as an auxiliary—as an organized group, every bit of service we do as an auxiliary reflects back upon the whole medical profession.

We are identified with medicine when we do these community service projects as an auxiliary, therefore it is very important that your wife and the wife of every doctor should be an auxiliary member. We have just about six thousand members, but you have over twelve thousand. You have forty county medical societies; we just acquired Auxiliary No. 32 just a couple of weeks ago in Merced. That is only 78 per cent. We need to have the other eight counties organized and need to get the other wives who should be and are not members.

We have to depend upon the cooperation of the doctors too. We alone cannot do it; it is your influence that is so very important. The whole thing can really be summed up in this one phrase—good public relations for you through community service by us; that is the sum total of our objectives and our organization.

Before I close I'd like to express a word of thanks. I think no State President was ever blessed with a finer State Board; the members have been simply wonderful. The county presidents have been most cooperative and helpful. Officers of C.M.A. Advisory Board, Mr. Hunton, Mr. Thomas and Mr. Gillette over at the C.M.A. office, and the girls there have been most cooperative and just delightful to work with.

I'd like to say just a special word of thanks to the Auxiliary and county organization of Kern County. I can't begin to say how wonderful they have been to me all year; they have furnished the inspiration to make this a good year.

I think the President's husband, as always, is a forgotten man, and he stays home and keeps the home fire burning while I run around for eighty-five days as I have done this year. If it weren't for his good nature and patience, this would not be possible.

In closing I speak for the five thousand nine hundred and seventy-eight members in California when I tell the organization that we are very proud to be doctors' wives, very proud to be members of the Auxiliary to the California Medical Association. We hope you are just a little bit proud of us, too.

PRESENTATION OF FIFTY-YEAR PINS

SPEAKER CHARNOCK: Thank you, Mrs. Miller. I am sure we are all proud of you and all proud of the magnificent work the Woman's Auxiliary is doing.

It is now a very pleasant duty to announce the presentation of the Fifty-Year Pin Award, and that will be done by your distinguished President, Dr. Morrison. I think we should have these people line up in front, Dr. Morrison.

PRESIDENT ARLO A. MORRISON: Will these gentlemen, if they are present, and ladies, please come forward? H. V. McNeil, Dr. Molony is going to accept his pin in absentia. John M. Wilson, Stella M. Zimmerman, Los Angeles County. From Monterey, Dr. Garth Parker; San Bernardino, John H. Shreck, and that will be accepted in absentia. From San Francisco, Milton Lenin, Harry Robarts and Hugo Wall. From Solano, Robert B. Dempsey; and from Stanislaus, Fred DeLappe. From San Bernardino, Dr. Carl Wente will accept the pin for Dr. Shreck. Will these gentlemen please come forward. Dr. Molony is accepting for Dr. McNeil.

DR. WILLIAM R. MOLONY, SR.: It gives me a great deal of pleasure to accept this fifty-year pin in the California Medical Association for Harvey McNeil. Harvey and I graduated together in Los Angeles in 1901. I entered the Association a year before he did, so that I got my pin last year. It is a real pleasure to accept this for him this year.

PRESIDENT MORRISON: Next is a gentleman who has been with us for fifty years, Dr. Fred DeLappe from Stanislaus County. Dr. DeLappe, I present you this pin.

DR. DELAPPE: Mr. President, I thank you very much, and the House of Delegates who have been so kind as to bring me this honor. I graduated in 1897 and have been in continuous practice until 1952. I thank you.

PRESIDENT MORRISON: Next is Dr. Garth Parker, from Monterey County—Dr. Parker.

DR. GARTH PARKER: Thank you very much.

PRESIDENT MORRISON: Next is Dr. Robert B. Dempsey, of Solano County.

DR. ROBERT B. DEMPSEY: Thank you, gentlemen.

PRESIDENT MORRISON: From San Francisco we have Dr. Harry Robarts.

DR. ROBARTS: Thank you.

DR. MORRISON: Dr. Carl Wente will accept the pin for Dr. Shreck, from San Bernardino.

DR. CARL WENTE: I may add about Dr. Shreck that he graduated from school in 1888, practiced in Illinois in 1889 to 1899, and came to Redlands, California, in 1902 from which time he has been a member of our association. The county society's records for the previous three years are not obtainable so that we have the record of his being present only since 1905.

SPEAKER CHARNOCK: Thank you, Dr. Morrison. At this time we will do honor to our Past Presidents; quite a group of them are here today. As you know, they sit in the house as members of this House and I should like to have them stand up, those of them who are here.

First Dr. Edward N. Ewer; he was president in 1925. Dr. Lyell C. Kinney, Dr. Junius B. Harris, Dr. Reinle, Dr. Peers was president in '35, Harry H. Wilson, Dr. William R. Molony, he was president in '42.

Dr. Karl L. Schaupp, Dr. Lowell S. Goin, Dr. Sam J. McClendon, Dr. John W. Cline, Dr. E. Vincent Askey. Dr. Askey is starting out all over again; he is a national delegate from Los Angeles, so starting all over on routine again.

Dr. R. Stanley Kneeshaw, Dr. Donald Cass, Dr. H. Gordon MacLean, Dr. Lewis A. Alesen. I saw Dr. Alesen just a week ago; he has been ill but he said to bring his best regards to you all. He didn't think he would be able to be up at this meeting; he was busily engaged in writing letters about the Bricker Amendment. The little man might be down at the moment but he is far from out.

Dr. John W. Green—I think we all owe a great debt of gratitude to the past presidents and the interest that they have shown in the organization.

At this time we have a few announcements to make. We welcome the press here today, there are members from the press here at the meeting and we welcome them to our deliberations. The C.M.A. office is in Room A. The Reference Committee rooms have already been assigned, with Reference Commit-

tee No. 1 in Room 2005, Reference Committee No. 2 in Room 2051, No. 3, the English Room, Reference Committee No. 4, in 2006, and the C.P.S. Reference Committee room is 2127. I should like to see the chairmen of each of these committees at the noon recess.

At this time it is nice to welcome all the delegates and alternates who are coming for the first time and I should like very much if all the delegates who are making their maiden appearance before our House of Delegates would please stand up. . . . Applause.

The resolutions which will be introduced this afternoon we are asking you to present in five copies, please, typewritten if possible. Stenographic service is available in the C.M.A. office room.

And at this time I should like to announce that caucuses for the First, Fourth and Seventh and Tenth districts will be held at noon today. The First District will meet in Room 3007, the Fourth District, Los Angeles County, will meet in this room at the noon recess. The Seventh District will meet in 2012 and the Tenth District, if they will let us know where they will meet we will announce it.

It is very appropriate that at this time we have a report by our President. For two years our President has been busily engaged in going to all parts of the state and meeting with all the county societies. He wants to bring you a report of his activities and it is a great privilege to be able to present our President, Dr. Arlo A. Morrison. Dr. Morrison.

[*Dr. Morrison's report was published in* CALIFORNIA MEDICINE, *June, 1955, pages 421 to 425.*]

SPEAKER CHARNOCK: Thank you very much, Dr. Morrison. We have a little special surprise for Dr. Morrison. I have here a picture of the California Medical Association meeting at Del Monte in 1899, and really it is a fine group of 29 distinguished gentlemen. Here it is.

This is interesting to Dr. Morrison because Dr. Cephas L. Bard of Ventura, who was president of the California Medical Association in 1897, is a member of this group. Dr. Morrison, we present that to you.

We have a couple of announcements now to make. All doctors and their wives are invited to the Auxiliary reception this afternoon between 5 and 7 in the Rose Room, honoring Mrs. Arlo Morrison. Tickets to the President's Dinner are on sale in Room A.

The Alameda-Contra Costa delegates and alternates will hold a caucus in Room 2127 at the noon recess.

VICE-SPEAKER WILBUR BAILEY (Los Angeles): We have further reports to what we have published in your preconvention bulletin which we will not read. There are some additions. On page 9, Report of the President-Elect, no addition. Report of the Speaker and Vice-Speaker, no addition there.

Report of the Council, by Dr. Donald D. Lum.

DR. DONALD D. LUM: Thank you, Mr. Speaker. A very short supplemental report will be in the form of a resolution to be entered this afternoon and a budget to be presented by the chairman of the Auditing Committee, Dr. Ivan C. Heron.

VICE-SPEAKER BAILEY: That will be referred to the proper Reference Committee. Next we will have the Report of the Legal Counsel, by Mr. Hassard.

MR. HOWARD HASSARD: Mr. Speaker and Members of the House of Delegates: There are several legal decisions subsequent to our printed report that appears in the preconvention bulletin that seemed worthy of presenting to you briefly this morning.

The first one involves the subject of group prepaid practice of medicine and it is a decision of the Judicial Council of the American Medical Association in a case involving one Dr. Landess of New York. Dr. Landess is a participating physician in the prepaid plan in New York City known as the Health Insurance Plan of Greater New York—HIP. HIP is not, strictly speaking, a closed panel plan; it has to be defined as an open-closed panel plan, or like a tall-short man. It is closed in the sense that subscribers to it may only receive their care from participating groups of physicians. It is open in the sense that any group of physicians practicing in the New York area in the group form may contract with HIP for the rendering of service. Dr. Landess belongs to such a group practicing in Jamaica, Long Island.

Dr. Landess was charged by his county medical society with unprofessional conduct in that HIP advertises in the public press in New York City and the theory of the charge against him was that any advertising by HIP constituted by indirection advertising on his part and on his behalf. His county medical society and state medical association both upheld disciplinary action against him.

He then appealed to the Judicial Council of the American Medical Association, which in February of this year reversed the decision of the state and county societies and in doing so stated as follows, and I am quoting from the Judicial Council of the A.M.A.: "Since on the record before us HIP is organized and operates in accordance with law and may lawfully advertise, since the quality of its advertising is not an issue, and since Dr. Landess had nothing to do with the preparation or distribution of the advertising, it is our opinion, contrary to that of the State and County Medical Society, that the conduct of Dr. Landess does not violate the ethics relating to solicitation and advertising."

The Judicial Council then pointed out that Dr. Landess' name did not appear in any of the ads, the advertising was for HIP in general, not for any of its participating physicians; it also pointed out that it was not passing upon any other ethical principles that might be involved in the relationship between HIP and its physicians, but solely upon the issues that were presented, charged against the doctor, that is, of the newspaper and other type of printed advertising.

The second case that I think is worthy of bringing to your attention—many of you already know about

it because we have had many inquiries—is a tax decision. It is a case that arose in Montana, was recently decided by a Federal court and involved the question of ability of a medical group to obtain a pension plan on a parity with employees in business and industry generally.

As many of you know, under our tax laws a corporate business entity may embark upon a pension plan for the benefit of its officers and employees and the premiums for such pension plan are a deductible business expense so that in net effect the cost is tax free. As you know, self-employed people such as physicians, attorneys, dentists, and others in the self-employed category, or groups of professional people who practice in a partnership form, may not do this; the law does not permit them to purchase an annuity or any form of saving for the future and deduct the cost from their income taxes.

I think that many people will agree that that is manifestly discrimination and manifestly unfair but to date Congress has not seen fit to extend to professional people who are self-employed the same opportunities to save for their older years that is granted to employees both in management and labor and industry generally.

Back to the case. A group of physicians in Montana took advantage of a peculiar section of our Federal Income Tax Law that was never designed for this purpose but ingeniously it was used. In our Federal Tax Law there is a provision that a partnership may be taxed as a corporation if in fact it operates similar to a corporation, that is, if it has a board of directors, if it has transferable interests, limited liability and various other attributes of a corporation. In tax language such a partnership is called an association.

This medical partnership in Montana organized as an association and then claimed tax status as a corporation and claimed that its partners were actually officers and therefore employees and that therefore it could have a pension plan and that it could deduct the premiums for that pension plan from its taxable income. The Federal Court held yes, that that was so, that it could do so, and it could deduct the cost of annuities.

The case is in effect a freak; it is one to be followed with the utmost of caution, and it involves collaterally the question of law and ethics with respect to the manner and form in which one practices a profession. However, the most important part of it is that it focuses attention on the inequity that now exists in the law, that it denies to all of you an equality with others in our community, the ability to provide for your older years without having to pay a tax on your savings.

The third and last case that I desire to bring to your attention was just decided this last Friday by our California Supreme Court and I am presenting it as an oddity of the law. As you have all doubtless experienced, in a personal injury suit frequently the defendant desires to have the plaintiff, that is, the complaining person, physically examined by a physician in advance of trial in order that the defendant may ascertain and have some knowledge of the actual extent of injuries.

In recent years there have frequently been disputes or controversies when such a physical examination has been ordered over the question of whether or not the attorney for the injured person, the plaintiff, has a right to be present while you examine the patient. Then in a recent case a test was made of this point of this issue, and the issue went to our California Supreme Court which rendered its decision last Friday. I will summarize parts of it and read a little part of it to you because I think you will find it is most startling.

This particular case involved a lady plaintiff; a court order required her to submit to a physical examination by a physician appointed by the defendant. She showed up for the physical examination accompanied by her attorney and refused to proceed any farther unless her attorney was present. The physician refused, whereupon the trial court ordered the plaintiff to submit to the physical examination in the privacy of the physician's office without anyone being present.

That order was appealed to the Supreme Court. The Supreme Court first agreed that the defendant has a right to obtain a physical examination and then it proceeds to say this, "The doctor should of course be free to ask such questions as may be necessary to enable him to formulate an intelligent opinion regarding the nature and extent of the plaintiff's injuries but he should not be allowed to make inquiries into matters not reasonably related to the legitimate scope of the examination. Whenever a doctor retained by the defendant conducts a physical examination of the plaintiff there is a possibility that improper questions may be asked, and that a lay person should not be expected to evaluate the propriety of every question. The plaintiff therefore should be permitted to have the assistance and protection of an attorney during the examination.

"It is argued that an attorney by making groundless objections may hinder an examination, thereby depriving the defendant of the benefit of an informed medical opinion. The plaintiff, however, should not be left unprotected on the assumption that an attorney will unduly interfere with the examination. Should such interference occur, appropriate steps may be taken by the Court to provide the doctor with a reasonable time to complete his investigation of the nature and extent of any injuries this plaintiff may have sustained."

The Court then reversed the decision of the trial judge to allow the attorney to be present during the examination.

In this particular case the examination involved was a pelvic examination.

VICE-SPEAKER BAILEY: As a matter of fact your last comment covered the question everyone had in mind.

Next we will go to Item 21, Report of the C.P.S. Board of Trustees, by Dr. Hodges.

DR. HODGES: Mr. Speaker and members of the House of Delegates: I am well aware of my own aversion to columns of figures and my impatience with statistics; I shall plague you as little as possible with these. It is my hope, however, that I can impart my feeling of enthusiasm in reference to the accomplishments of California Physicians' Service during the year just concluded. It is a significant year; the important agency you established to aid in the solution of the knotty problem of medical economics has not been idle.

It is the heartfelt wish of your Board of Trustees and the administration that it has acted always wisely in your behalf. Even more important, in discharging our duties we have been impressed increasingly with the original purpose of the foundation, that the purpose should be to offer an adequate method of paying in advance for the cost of illness. We hope most earnestly that we have acted also in the public's behalf, as our state's physicians would have us do.

Were it not to the advantage of those who chose to be our subscribers C.P.S. would have no excuse for existence. Your Board has labored mightily and long. I find that, fortunately, from many branches of medicine and from the laity you have developed its composition and you may be assured that your elected members have acted for you only after deliberation and sober thought.

It is to be expected that your confreres will serve for you on the basis of their normal community duty but you and I are also deeply indebted to the laymen on our Board who, with no personal axes to grind, have brought to us their energies and talents. Let me call their roll.

Msgr. O'Dwyer, eminently fitted because of his responsibility with Catholic charities, additionally qualified as a member of the Blue Cross Board, an experienced and wise advisor; Thomas Hadfield, who brings to us his association with the great insurance industry. It takes little imagination to conceive of the value to C.P.S. of his insurance know-how. Countless times he has brought us to earth by his sound business counsel, based upon all the years of trial and error of his own great business; and

Ransom Cook, senior vice-president of the American Trust Company. You may remember his excellent address to the House of Delegates two years ago. If you detected his gift of analysis then, think of what his return to the Board has meant to us this past year.

Robert Hornby, executive vice-president of the Pacific Lighting Corporation. Mr. Hornby personifies the bird dog of industry; he is not content to accept as fact that which is presented to him—he has to examine it, he must test it, he must prove it. No rotating rock within his jurisdiction rests secure from overturning and examining. Furthermore, he is an expert on labor relations and labor's aspirations in the field of security.

The late Carey Hill, respected investment counselor, of Los Angeles. His absence will be conspicuous, for although not well, he labored ceaselessly to learn all possible about our profession, the better to act for it in the complicated business of medical cost prepayment. Despite his ailing heart he spared no effort to serve C.P.S. whenever needed.

You know much more of the physician members of your Blue Shield Board of Trustees; they are dedicated to C.P.S. principles and serve gladly for this cause which is by nature their own. But we owe a deep debt to our lay trustees; they have conveyed to us, and accurately, the desires of the public. They have shepherded our funds, our reserves so that fees to the doctors and benefits to the subscribers could be realized to the maximum; by their countless committee meetings and their board meetings since, they have brought us balance.

It is time also to express our gratitude to Dr. Frank MacDonald of Sacramento, who now leaves the Board. He has chaired the fee schedule committee of the Board and has been a tireless and valued trustee for six years. He will be missed.

A few years ago it had been felt that C.P.S., a natural child of C.M.A., had lost contact with its parents. For this reason three members of the C.M.A. Council ever since have been appointed to the Board of Trustees. The result has been fortunate in the extreme; the benefits are too many to enumerate. All deeply desire that these aims shall continue.

Your whole Board, by profound study of it, have more information on the subject of medical cost prepayment and have, I believe, qualified themselves as informed students of this field. There is not a dilettante among them. Incidentally, it should not go without mention that last year one of C.P.S.'s indefatigable workers and former presidents, Frank Doughty, died in Tracy of a heart attack. You all remember his devotion to this cause.

We are vastly encouraged by the ever-growing support accorded Blue Shield by our physicians. More doctors are members than ever before. As of March 31, 1955, there were 12,256. This is a vast majority of those in practice. The greatest number of newly licensed physicians become members at once; resignations are at a new low point and a substantial number of those who have resigned have once more, upon application, been reinstated. This demonstration of confidence in C.P.S. and its method of operation is encouraging to those who have loyally supported it through its years of trials and tribulations and through its errors. This support has been expressed in more tangible ways; more and more we have found physicians interested enough to appear before groups of potential subscribers, campaigning for their plan and explaining it to those who desire effective prepayment coverage. We can attribute our success in enrolling numerous groups to the selfless efforts of these many doctors.

The development of special programs for different county societies, the establishment of committees within county societies to review unusual claims, the extension of the program of decentral-

ized contact with physicians, the closer relationship between C.M.A. committees, such as the Medical Services Commission, with representatives of C.P.S., all have resulted in a better understanding of the overall needs in this field of prepaid medical care.

Many leaders of the medical profession and literally thousands of doctors now realize that there must be an organization such as C.P.S. if they are to be adequately represented at the bargaining table. It is true that some physicians do not favor the principles of C.P.S., who doubt the wisdom of its formation, and some even feel now that it should be drastically curtailed. These men are sincere in their conviction, are far fewer in numbers since the correction of a number of past defects, and many are convinced that such improvements have rendered C.P.S. a much more effective instrument in the field of medical economics. The physicians' relations department is working diligently there to win those whose resentment may be based upon misunderstanding. The Board is equally as desirous of changing the policy so that there may be no false basis here for lack of support.

Every effort must be made also to maintain our public relations at the highest possible level and those in administration charged with these duties are directed to this end, but we all realize that the most competent public relations agent is the enthusiastic, satisfied, practicing physician of the subscribing membership.

Our total number of beneficiaries continues to grow, as was to be expected in a rapidly growing state. Subscribers numbered 700,096 on March 31, 1955, an increase of 10.95 per cent for the year. Our dollar income is at the highest level in our history, that has enabled us to liberalize benefits, to pay on an increased fee schedule, to pay the increased fees to physicians effective since January 1, 1954, and to maintain our vital reserves within the range advocated by the National Association of Insurance Commissioners.

To show that this financial stability maintenance is solid evidence of sound management, operating costs are the lowest in the history of C.P.S. The most recent estimate of administration expense is 9.3 per cent, is most favorable as compared with other Blue Shield plans, and most favorable as compared with our experience of a few years ago when operating costs were as high as 17 or 18 per cent.

Relationship with Other Blue Shield Plans. This of course is becoming important since more and more nationwide industries, unions and other groups are seeking means of covering these groups by medical and hospital prepayment plans. The preparation of federal legislation to provide for contributions on the part of the government and payroll deductions to finance such coverage has again emphasized the need for unified action by all Blue Shield plans. Those two and a half million employees could thus be retained within the private or free practice of medicine and California has the largest stake of all, not excepting the District of Columbia.

Your president and members of the C.P.S. management have been active in working with the Blue Shield plans in the eleven districts on the Pacific Coast as well as other Blue Shield plans throughout the nation. There has been active participation in the management of Medical Indemnity of America, the insurance company owned by the National Blue Shield, and California has been represented on the Blue Shield Commission by two of its doctor members. At a recent meeting in Chicago your president was elected vice-president of the National Blue Shield Commission and every effort is being made to work harmoniously with these other plans on national programs that indirectly affect conditions in each of the various states.

The Development of New C.P.S. Contracts. No more intensive study has taken place than that by the Contract Committee under Dr. Reynolds' administration, and by the Board of Trustees. This commission determined to offer California organized group contracts which would better consider their individual needs and borrowed from Oregon the building block principle. A basic uniform contract with broad standard benefits is the foundation. Other building blocks with certain units of extended coverage may then be appended so that the negotiating agency can tailor its master contract to its need and the funds available. Offering of these new group agreements will be determined by the specific need of each organization considered.

C.P.S. Protection. Our contracts are making friends for C.P.S. A similar contract has been provided for sale to individuals who do not qualify for coverage under group contracts, a long felt need. Broadened benefits and rates that are not materially increased make this a good buy. It is at first being offered in selected areas where county societies specifically request its sale. Principles will be closely studied and we hope it will demonstrate the physical soundness of this type of coverage.

Similarly, the Contract Committee has recently approved of broadening the benefits and increasing the coverage of direct pay contracts. It is possible for a member of a group who leaves that group for any reason to continue coverage within C.P.S. as long as he may live. This represents at least a small effort by medicine to help the aging to solve their problems.

Incidentally, the attitude of the new printed contract is revealing; it is as foolproof as it can be made. There is no small print in the margin. There is an explanatory column entitled, "Benefits Defined." There is a growing demand for a major illness expense contract that will cover 75 per cent of medical, surgical and hospital bills after the benefits in the base contract are used, with a total dollar limitation high at $7,500.

We will report to you the availability of this important protection against major expense of serious accident or prolonged illness at an early date.

Sale of Indemnity Type Insurance. It will be recalled that the California Physicians' Service organ-

ized an insurance company known as the California Physicians Insurance Corporation on the recommendation of this House of Delegates. C.P.S.-Blue Shield has been requested by the House of Delegates to work only with those county societies requesting that this form of indemnity insurance be written in those counties. Within the past few months two counties have made such requests and C.P.S. staff members are now working with authorized committees of these county societies.

The activities of this insurance company may be extended as needs require.

Local Area Programs. As physicians have become increasingly faced with the problems that make covering for sickness cost necessary, they have also been aware that the perfect plan has not yet been devised. This has led them to search for a solution based upon the need they find in individual areas. We find that sort of research in the Palo Alto Regional Plan, in Long Beach, Santa Clara County, San Pedro, San Joaquin County, and elsewhere. This is a trend worthy of consideration.

It is the policy of the C.P.S.-Blue Shield to operate with any groups on local competitive or other problem, and to aid them in developing contracts and plans likely to meet these local conditions within the framework of the C.P.S. structure. Even where the results of such study may not have been a new type of contract we have found the greatly stimulated interest of the physicians has created new knowledge of this difficult field, for the principles and standards, if they are a clearly defined set, are often illusive and defiant of comprehension. These newly self-informed doctors have been a great aid in accelerating progress in this field.

One phase of this area development has been the adoption of the $6,000 income ceiling with the appropriate Fee Schedule B, in counties where either C.P.S. contracts with a $4,200 or $6,000 income ceiling and/or both was essential. It is remarkable that the C.P.S.-Blue Shield organization has proved effective in developing programs where contract benefits vary, where there are multiple income ceilings and dual fee schedules. Should a $6,000 income ceiling be adopted statewide there still remain many problems confronting county societies which will only be resolved as plans are tailored to fit the differences as they now exist.

At a recent meeting of the Trustees of C.P.S.-Blue Shield this policy of working closely with any county society having problems different from other areas was reaffirmed. It was hoped that the carrying out of this program will make possible the rendering of even better service to the people of the various areas and the physicians who are seeking solutions to their ever-changing problems of financing the cost of medical, surgery and hospital care. At the same time it is realized that there must be sufficient uniformity to avoid confusion and inefficiency of operation.

Broadened Field of Special Services. Dr. Morrison has alluded to this in his address this morning. It may well be that this year in the widening of our growth potential for service to physicians and to the public, the existence of a body like C.P.S. makes it possible for organized medicine to offer a program to varied groups who might otherwise be forced to look elsewhere. There is an obligation peculiar to our profession to assure our consumers that they shall be able to avail themselves of our essential services. This is a polyglot field but C.P.S. can be the instrumentation.

The first example is the Veterans Home Town Care Service. Blue Shield has retained for private practice the ambulatory veteran with a service connected disability. It has required a continuing effort on the part of the administration to do this, for the contracts with the Veterans Administration are renewable yearly. Because of this effort we anticipate contract renewal on July 1 with a substantial increase in the fees paid to physicians.

An increasing load of indigents in the state has brought into sharp focus the need of devising new methods of serving them most adequately within the amounts available from their contracts. The Medical Services Commission has assisted in a program for caring for them and your Board of Trustees has approved it. Thus it can be shown vast savings can be realized, duplicity of new hospitals can be avoided, and the existing structure of medical practice maintained. One rural county alone estimated an annual savings of $48,000. Requests have been received from Imperial County, Orange, Riverside, Sonoma, Santa Cruz, Marin County and others for C.P.S. to develop suitable programs. It is anticipated that we can do that on the basis of financial soundness and a fair return to the doctor.

Because of a bill now before Congress to provide for the tendering of care to dependents of servicemen by private physicians, the staffs of C.P.S. and other western plans are consulting so that we may offer suitable contracts. You are aware of the work of Dr. Lambertson and his committee in studying the problems of financing medical care for the aged. Blue Shield has been in contact with him, aiding in the development of some workable plan. Many large employers are bound to include their retired people in their health and welfare programs. C.P.S. has seen the possibilities in such groups.

Coverage of the unemployed is another field C.P.S. feels it should explore. Conditions are such at the present that serious study should be made and a plan evolved so that the health needs of these people may be paid for when needed.

We have entered into the area of contracts covering students of several colleges and the program has been working most satisfactorily. People at medical societies themselves have required such programs and have sponsored them. There is a demand for an extension of this type of operation and wherever the local profession desires this we are ready to underwrite such plans. It might be observed that young persons of impressionable age, some inexperienced in individual private practice, are shown by example something better than this corporate practice they find in some institutions.

Conclusion. As I view the overall picture of C.P.S.-Blue Shield I see its potential for usefulness vastly increased. I anticipate a period of broadened service, never conceived of by its founders. I feel that our increased capacity for rendering a service both to our profession and to the public should not escape our notice. Through your own plan which is ably administered under the most effective public relations now within your grasp, one that no amount of canned campaign can touch, with your enthusiasm and your support C.P.S. can succeed mightily, not by being a reaction against something, but as your own unbeatable leader in a field that should be your own. Thank you.

VICE-SPEAKER BAILEY: That report will be sent to Reference Committee on C.P.S. Business—this very encouraging and well done report by Dr. Hodges.

Now the Chair proposes to deviate from the usual order of business, a deviation which will require the unanimous consent of the House. Dr. Malcolm Merrill, State Health Department Director, regularly meets with the Council and the Council has requested him to report to the House of Delegates on the polio vaccine problem. The Council appreciates the fact that Dr. Merrill has kept in touch with Dr. West and others of our group. I believe there would be no objection to introducing Dr. Merrill at this time. If there is no objection, I will present our old friend, Dr. Merrill.

REPORT ON POLIOMYELITIS VACCINE

DR. MALCOLM H. MERRILL: Mr. Speaker, members of the House of Delegates: Last Tuesday morning at 10:30 a.m. we received a telephone call from Dr. Walter Ward of the Cutter Laboratories advising us that they had just received word of a possible case of poliomyelitis up at Napa in a child who had been vaccinated a few days before with Cutter vaccine. He also indicated that they had a comparable type of report from Chicago, concerning a child who had been inoculated there some five or six days previously with Cutter vaccine. This immediately started in motion a rather extreme search on our part as well as on the part of Cutter Laboratories for possible other cases.

Within a few minutes we had additional reports of two cases in San Diego and within two or three hours we had a report of a case in Ventura, and a suspected case in Children's Hospital here in San Francisco.

By evening we had what appeared to be six bona fide cases. We had in the meantime asked Dr. Edward Shaw here in San Francisco, together with members of our staff, to go into the clinical manifestations of the Napa case, and serve as consultants to our department to help us look into this case. We also began an immediate investigation of the suspected case in San Francisco and of the case in Oakland. By late evening it seemed clear that we had six bona fide cases, varying in duration of onset from five to seven days from the time of inoculation, with a clinical picture that was rather constant in appearance of paralysis first in the inoculated limb.

We had been in contact throughout the day with the National Institutes of Health, alerting them within a few minutes, as had Dr. Ward, of the time of the announcement of the first case. By midnight the pattern was sufficiently clear that we as a State Health Department were prepared to recommend to the National Institutes of Health that they give serious consideration to the possibility of withdrawal of this vaccine. Their deliberations carried throughout the night and by 8:30 next morning we had Dr. Ward's and Dr. Cutter's request for the temporary withdrawal of the vaccine from the market. Since that time a most intensive hemological study has been made and most intensive search has been made of possible additional cases that may have occurred.

Up to this time—and I am depending partly for my assertion on the epidemiology that has been done by the press throughout the nation—it would appear we had some 32 cases in which there was a previous history of an inoculation of certain batches of this vaccine. Seventeen of these cases have occurred in California. To give you a rundown, there are five cases now in San Diego, six in Los Angeles, one in Ventura, one in Napa, one in Riverside, one in Stanislaus County, and two in Oakland.

We immediately began trying to figure out what is the denominator as it occurs epidemiologically. That is, how many children in California received the vaccine. We still don't know the answer but it appears somewhere in the neighborhood of 200,000 of these children have received Cutter vaccine, the first dose of Cutter vaccine in California. This number of approximately 16 or 17 cases is somewhere in the neighborhood of one case per 12,000 inoculations.

You may be interested as to the next point in knowing what happened to the polio incidence throughout the state this year, the totals. That is an important consideration for us in trying to determine whether or not the vaccine really had anything to do with the production of the paralysis in the reported cases. There has been a lessening of incidence in the past three years. In 1953 up to the second of March we had 495 cases; in 1954, 366 cases; 1955, 198 cases. During the month of March of this year we had 54 cases reported. In the succeeding four weeks these are the reports that came to us—the week ending April 5, seven cases; April 9, eight cases; April 16, nine cases; the week ending April 23, 16 cases; and in May, 16 cases.

We have had experience, then, of rather low incidence throughout the year thus far.

The next question you may ask is how many cases have there been during the past week that have not been inoculated. These data are incomplete because we are getting telegraphic and telephonic reports on cases that had been inoculated. Up until the last day or two we have not been getting reports on such cases up to this moment. We had three noninoculated cases last week and one addi-

tional perhaps suspect, but we won't know for a few days yet just what is the picture in uninoculated cases for the past week.

Another question we are vitally concerned with is what is happening with other vaccines throughout the country. We have been in communication with the Public Health Service, National Foundation for Infantile Paralysis, antibiotic and pharmaceutical houses, and most of the state health departments. This morning we had information on one case in Georgia, onset within three days of inoculation with Eli Lilly vaccine, one in Houston, Texas, which we do not have details on as yet, and there are two Louisiana cases. There have been a number of additional cases in Oakland with Cutter vaccine. From outside the state, at least, ten in Idaho, one Chicago, 21 in St. Louis, one in Denver, and one in Washington, and the questionable two in Omaha, giving us at this time what appeared to be 32 cases.

Indications are that some three and a half million children at the minimum throughout the country have been inoculated with vaccine since it was released on the 14th. Actually it was the 15th or 16th before it actually got into the market at school inoculations, and some three and a half million people have been inoculated since that time. We don't know exactly; these have been done in some 28 states plus the District of Columbia and Hawaii. This is the only apparent break that has come to our attention, with the exception of the three or four cases that I mentioned.

With this information a rather clear cut picture emerged and on Wednesday morning there were news releases issued by the National Institutes of Health, by the Cutter Laboratory and by our department simultaneously. Telegrams went to all local health officers to discontinue further inoculations with Cutter vaccine. You will recall Cutter vaccine was distributed to all counties in the state—Stanislaus, San Joaquin, and all counties of the south. Another vaccine was distributed here in northern California and that vaccine came to us a week later than the Cutter vaccine.

We did not request discontinuance of immunization with vaccines other than the Cutter product until after a meeting with our Polio Advisory Committee on Friday. That committee, as you probably know, is composed of a public health committee in addition, so there are some 18 members on the committee. Three members are from the Council of the C.M.A., three members who constitute the Public Health Committee that works closely with our department. We met with that committee for a rather prolonged meeting on Friday afternoon and out of that meeting came several specific recommendations which have been publicized in the press and you have probably seen them.

We did not recommend the use of gamma globulin to the inoculated children. We recommended that the children receive continued observation, that on any abnormality appearing their family physician be immediately contacted, that they adhere to the general policies that we give during polio epidemic seasons of avoidance of excess fatigue or chilling or excess exertion. One additional recommendation was that any elective surgical procedure be delayed for a minimum period of three weeks, and finally it was recommended there be a temporary suspension of all polio injections in California until further notice and a period of one week was mentioned in the recommendation of the Advisory Committee.

When we took this action for a suspension, the situation was quite confused. By afternoon, in some respects, we had incomplete data of what was going on throughout the rest of the country. There was in session at these same hours a meeting of technical advisors to the National Institutes of Health in Washington. Our committee felt they were desirous of having the regulations that come out of the Technical Committee before they wanted to agree to the continuance of the inoculations in California.

Careful study now is being made of any recommendations that have come out of that committee and it is hoped there can be an early announcement of the resumption of vaccination in California. In this morning's news releases I notice that California and Vermont are the only two states in the nation that have temporarily suspended inoculations.

The rather confused situation here the last few days we feel is ample justification for the action that was taken and recommended by our Advisory Committee and taken by the Department.

Now a word about the supply of vaccine. You will recall that there was a week's delay in our getting enough vaccine in the northern California area. What has come in is distributed and available to all local health departments. With the withdrawal of Cutter vaccine we needed to replace that. The replacement vaccine arrived yesterday and is now on hand for the continuance of the first injections of the first and second grade children. It is anticipated that there will be an adequate supply to continue the second injections when they become due.

I am sure you are interested in what the anticipated supply is nationally and is expected to be nationally. When there were six producing companies, that is, before the Cutter material was temporarily withdrawn, it was anticipated there would be enough vaccine available very soon after May 1 to take care of the 8,600,000 children in the first and second grades, countrywide. It was felt certain that by May 15 it would be available and we were advised that somewhere around May 15 or soon thereafter vaccine would again be appearing through the commercial channels.

By June 1 it was anticipated there would be enough vaccine nationwide for 16 million injections, enough to cover 40 per cent of all the children in the one-to-nine-year age group; by July 1 some 25 million doses, enough for some 25 million inoculations, which would cover approximately 75 per cent of all children between one and nine years of age.

By August 1 it would be anticipated that there would be enough vaccine for all children up to 10 years of age, that is, one through nine. And by Sep-

tember 1 enough for all children up to 20 years of age.

From this you can see it is anticipated that the supply will build up rather rapidly within the next few months. Nevertheless there can be an intervening period of short supply; that is one of the things that concerns you. I know it has been discussed in many of our county societies, and is of concern nationwide. We act here in the manner of an advisory board to Public Welfare in Washington, to advise the Public Health Service and press of our country on how this should be handled. Out of that meeting came the recommendation that it should be allocated on a voluntary basis, but that the allocation should be made to the respective states on the basis of the estimated polio in the age group one through 19. Each state should name the individuals or groups within the state that would develop the recommendations for allocation within the respective states.

The Governor of each state was requested to make such a designation. In this state the Governor designated the Director of Public Health with the understanding, of course, that there would be an advisory committee to work with the Department of Public Health in the Department's recommendation, with reference to allocation within the state.

In the rush of the last few days we have made no move up to this point other than a preliminary consideration on the possible developments of the Advisory Committee. This problem has been discussed briefly on two occasions with our current Polio Advisory Committee so that we are beginning to get some background information with reference to it. In the next two days, however, there is a problem we will need to face in a very realistic fashion on the development of our state recommendations for all occasions.

There will be a meeting in Washington tomorrow, the first meeting of the Advisory Committee that has been appointed nationally for the development of recommendations on local adoptions to the state. It will be anticipated that by tomorrow night or Tuesday we will have some recommendations as a background with which to work.

Now with reference to what is going on in the state as of now. Every case that is being reported, both inoculated and uninoculated, is being subjected to rather extensive hemological studies. We would like to urge that you as physicians, and through you all physicians in the state, keep careful records of every number that is inoculated in every individual and a careful record of any reactions that have developed. We find some defects in recording of lot numbers which have materially retarded and interfered with our studies in the present situation. That is an important assistance that I am sure you can give.

We will also be asking you to assist in the follow-up of these cases. We are attempting to do the same type of intensive follow-up, particularly on the inoculated cases, as was done last year with extensive nationwide trials of vaccine. During the trial period we will be collecting blood specimens, taking specimens from any known infection. Particularly we feel that we should be in the forefront nationwide, and that if any mortality results from vaccinated cases that we get autopsy material so that the diagnosis, in so far as possible, can be completely affirmed.

We would also like to be consulted on the allocation of priority as to who gets the vaccine first. I have indicated that as we go through the summer, if the Chicago situation carries out as currently anticipated, we will be able to take care of most of the children before we'd hit the normal peak of our polio incidence throughout the state. Nevertheless, there will undoubtedly be a clamor for some weeks and a lot of competition as to who gets the vaccine. There will be a recommended age distribution pattern from the State Polio Advisory Committee, submitted in preliminary form and we hope to have a recommendation before you leave here Wednesday.

I think, Mr. Speaker, that about gives a rundown on the current situation as we see it in our view of this entire problem. I like to think of what happened a few years ago when we first began flying DC6 planes. I happened to be on one of the first DC6's that flew east from here and it was two or three days later that there was the first crash and a few days after that a second crash and then all planes were grounded until a thorough study could be made and a determination made as to what had happened. Since that time I have had the pleasure of riding, I am sure, more than a hundred thousand miles in DC6 airplanes and have felt secure with them in those trips. I think we are confronted here with perhaps a comparable situation, something in which we don't know what has been going wrong, which may be a coincidence, but something we feel subtracts from the use of this most valuable biologic that has within it what we hope to be the control of this very serious disease. I thank you very much.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Merrill. The House now has the situation in mind up to at least 11:00 o'clock this morning. We do not want to miss the opportunity of telling Dr. Merrill how much we appreciate the incalculable value of his regular appearances at the Council meeting. We benefit from his attendance and sometimes maybe he benefits from our opinions.

We will now have the report of the Auditing Committee, Dr. Heron, on the budget.

AUDITING COMMITTEE REPORT ON BUDGET

DR. IVAN C. HERON: Mr. Speaker, members of the House: Your Auditing Committee each year has the duty of reviewing the budget of the past year in comparison with the expenditures, and then after considering the budget submitted by the various committees and commissions the promulgation of the new budget for the coming year. This was done and presented to the Council. The Council made some changes and your Speaker has requested

that we go down this more or less item by item so you may know where your money is being spent.

You will notice as far as income that your 1955-56 budget proposed the expenditure of income of $620,000. Dues of $470,000 were estimated last year and $480,000 collected. This new budget is based on annual dues recommended by the Council of $50, $3 of which is allotted to the Journal. You notice here the 1954-55 budget estimate and the estimated expenditure under that budget by the June 30 end of the fiscal year. The estimated income from the Annual Session, the Postgraduate Session, the interest, are about the same. You will note interest on the invested funds has dropped.

We come now to the proposed expenditures—Administrative, Rent, Telephone and Telegraph, Postage, Office Supplies and Expense, Equipment Expense. Los Angeles Office Expense is somewhat reduced, otherwise those have been approximately the same as estimated the previous year. Estimate of Administrative Salaries will remain the same. Estimate of the Clerical Salaries to provide for additional clerical help needed by our Executive Secretary, Payroll Tax Expense, Legal Department, will remain the same; Travel Expenses of Officers, Council, Executive Secretary, and Secretary are estimated to be approximately what they were last year.

The Meeting Expense—you will note the Annual Session next year is estimated to be a little less expensive than in San Francisco. The A.M.A. Delegates will be estimated the same as last year and will be a little bit less than the amount that will be spent this year because of the shorter distance of travel. The Secretarial Conference is the same. The Conference on Physicians and Schools is a new item which has been very, very productive of good relations to the medical profession and that is planned to be expanded on nine general meetings next year on a budget of $6,200. The Student A.M.A. is the same and well worth it.

The Woman's Auxiliary—you heard this morning what you support—remains the same as it was the previous year. The Council and Executive Committee the same. We come now to Organization Expense, which embodies Mr. Waterson's activity. You will notice that has been reduced from an estimated $188,000 at the beginning of last year, which was admittedly high, to an estimated actual expenditure of $80,000 and our proposed budget of next year in this activity will be $48,000.

Miscellaneous Expenses, estimated about the same.

The Scientific, Education and Public Relations—these are based on estimates of the forthcoming year submitted by the chairmen of the committees and commissions. The Cancer Commission will be a slight increase over what was estimated to be spent this year. Blood Bank Commission, the same; Postgraduate Committee, the expense will be estimated at a little more, $33,900 to be exact, to provide for an additional helper to schedule and program the conferences.

The Medical Services Commission will remain the same. Other committees about the same. The Department of Public Relations, due to less activity, will be $15,000 less than last year.

Department of Public Policy and Legislation will be estimated the same as the previous year.

Contributions to Benevolent Fund the same. Actually that should be classified as an allocation because the Constitution and By-Laws require this to be put aside for benevolence.

Contributions to Medical Library, Contributions to Nurse Recruitment will be the same. Contributions to Medical Education Fund is represented in the $10 increase in membership dues by the Council, to cover California contributions to this most necessary cause.

The Committee on Malpractice Insurance was a new responsibility and statewide activity is budgeted for $19,000. That gives us an overall budget for the coming year of $704,018. You will note last year we budgeted $793,000 with an estimated deficit of $280,000, but on the basis of money spent it seems our deficit this year will be about $45,118. The 1956 deficit of $109,118—as you know, the budget is prepared fairly generously in allotting this money to spending but each year the fees, the expenditures are quite a sizable sum. It may be that the budget will come out about even.

On the next page you have the proposed budget for CALIFORNIA MEDICINE. You will note they anticipate $15,000 additional income over that estimated for last year. That is from advertising sales. The balance of the income will remain about the same so that they anticipate $17,000, or $17,000 approximately over what was estimated would be coming in at the first of last year.

The expenditures, as you can see—printing expenditures will be up to $110,000 approximately, and the balance of the expenditures being listed as about the same, so that your total expense budget for CALIFORNIA MEDICINE is estimated at $168,850 which would return a net income this year of $21,000.

VICE-SPEAKER BAILEY: This report goes to Reference Committee No. 2, on the budget.

SPEAKER FROM THE FLOOR: Prior to that time, Mr. Speaker, we had an idea we might allow the fee, contribution last year, to medical education. In the previous year we had this $100,000 item which began in 1954. Is that proposed $130,000 to be taken from increased dues?

DR. HERON: That is correct; on an estimate of 13,000 members.

VICE-SPEAKER BAILEY: How about last year?

DR. HERON: That was taken out of current funds; that was one reason for the deficit last year.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Heron; this goes to Reference Committee No. 2.

I notice that since we have recognized our past presidents, Dr. Samuel McClendon, from San Diego,

has come in. His term was in 1946. Dr. Samuel McClendon, stand up and let us see you.

Thank you, Dr. McClendon. When I said that some of our past presidents were starting to work again I forgot to mention that Dr. Cass has done one better and is a whole delegate, not just an alternate.

If no objection the House will be in recess.

... The House went into recess at 12:00 o'clock noon.

Sunday Afternoon Session

The Sunday afternoon session of the House of Delegates of the California Medical Association was held in the Ballroom of the Sheraton-Palace Hotel, San Francisco, California, Sunday, May 1, 1955. The meeting was called to order by Speaker Donald A. Charnock, of Los Angeles, California, at 1:30 p.m.

SPEAKER CHARNOCK: Ladies and gentlemen, will you please come to order. It has been reported that there is some difficulty with the sound in the lower part of the room. Dr. Wisner, will you please close that big door down there so the sound effect will be a little better.

We are very apologetic starting this meeting as late as we are, but there has been difficulty in everybody getting something to eat due to conditions beyond our control. At the present time we would like to hear the report of the Committee on Postgraduate Activities, by Dr. Edward C. Rosenow, Jr. Dr. Rosenow.

REPORT ON AUDIO-DIGEST

DR. EDWARD C. ROSENOW, JR.: Dr. Charnock, Mr. Speaker: This is not a supplementary report about Postgraduate Committee but a report to the House of Delegates on Audio-Digest which a year and a half ago this House approved taking over from Mr. Pettis.

The main problem that concerns many members of the House at the time this was taken over was whether or not this new method of postgraduate education would stand a chance of costing the C.M.A. some money.

After looking into the budget this morning I am a little ashamed to bring up such small amounts of money as Audio-Digest has used from the California Medical Association treasury. A year ago we had 350 subscribers, and at the present time we have over 2,500 subscribers in all states of the United States, and about 12 foreign countries, to the five different digests we have.

We have a digest in General Practice, one in Internal Medicine, one in Surgery, one in Obstetrics and Gynecology and one in Pediatrics; another interesting fact I think for you to know is that we have been in business long enough to get some experience on the rate of resubscription on the Digest, and in no month have we fallen below a 65 per cent resubscription rate, which I think is very good.

The amount of money advanced by the Council for the beginning of this baby was $20,000, of which $10,000 was actually made available in money. We have not yet returned this $10,000 to the state treasury because of a number of reasons, but we have the money, we can return it at any time on demand. However, in the working out of a nonprofit organization there are some reasons for keeping a little money of the California Medical Association tied up in this.

We have over $100,000 in the bank to take care of unexpired subscriptions and your Board of Trustees feels that we are in a very sound financial position.

Aside from the financial aspect of Audio-Digest I think you ought all to take pride in the fact that that method of digesting medical literature has filled a service to man and to individuals to get a scanning of the literature without going to libraries which are not available to most men. We are able also to note revisions in the new methods of group study, and we have evidence that there are a number of Audio-Digest clubs and groups that get together from time to time to listen to our tapes and discuss them.

This is all a pretty good idea in postgraduate education, I think. Now where we have 2,500 subscribers probably we have conservatively at least three times that many doctors who are actually listening to our tapes. I think we ought all to be happy to know that we are providing that much interest in medical literature.

And then finally I would like to tell you that we have had many reports from various areas that would bespeak that the California Medical Association in this instance, as in many others, is leading in the field of getting things done in medical public relations. I will quote to you from the *New England Journal of Medicine* which adopted the program to start with and it said, "California is maintaining its reputation for doing things in a big way, high, wide and handsome," and we have many other testimonials to the fact that Audio-Digest is doing for the California Medical Association a great deal of good in public relations. For that reason I think you should all be proud to feel that you have a part in this.

I am, I am sure, very unhappy because I guess we are so busy taking care of our subscribers that we weren't busy taking care of selling you fellows. I was going to get a little packet of descriptive material about just where you can get the material for your own personal use and how much it would cost you and the kind of information we give out to people that ask for our service, but it hasn't arrived and I will pass it out to you when it does arrive. It may not get here until the Wednesday meeting.

If there are any questions any of you have about Audio-Digest I'd be very happy to try to answer them either now or after the meeting.

SPEAKER CHARNOCK: Thank you very much, Dr. Rosenow. This will be referred to Reference Committee No. 1.

There are a few announcements. The counties of Riverside, San Bernardino, Imperial, Orange and San Diego will have a formal meeting in Room 2062 at 9:30 on Monday. The San Francisco delegation will have a caucus at 9:30 Wednesday morning in Room 2040. There will be a caucus of delegates from District 11 in Room 8045 to convene one and a half hours after the adjournment of this House this afternoon. District 11 comprises Alpine, Amador, Butte, Colusa, Nevada, Placer, Plumas, Sacramento, Sierra, Siskiyou and Yuba counties.

Dr. Herbert C. Moffitt, the president of the San Francisco Medical Society, wishes to make an announcement at this time.

DR. HERBERT C. MOFFITT: Our San Francisco Medical Society has recently opened its new Headquarters Building at 250 Masonic Avenue, near Turk. Some months ago when it looked as though we would be able to open our building we asked the officials of the C.M.A. to use our facilities but they felt they were a little far removed from the centers of activity here in town. We hope, however, that the House of Delegates and friends will come out to visit our new headquarters and new blood bank any time you are in San Francisco.

SPEAKER CHARNOCK: Thank you very much, Dr. Moffitt. At this time we would like to have a report of the Committee on Public Policy and Legislation, Dr. Dan Kilroy, of Sacramento. Dr. Kilroy.

PUBLIC POLICY AND LEGISLATION

DR. DAN O. KILROY: Mr. Speaker, members of the House of Delegates: Your Committee on Public Policy and Legislation has served you faithfully and we hope well since our previous report to this House one year ago. Your committee has met with the Board of Medical Examiners to assist them where possible on legislative requests arising from that Board.

The committee has met for a consideration of the approximately 6,000 bills which were introduced in this session of the Legislature, from which group 500 bills were found affecting in one way or the other the practice of medicine.

Your committee has also met with the allied health groups, where there was a fruitful discussion of all those profuse major measures affecting us; therefore I will make no attempt to carry on a discussion of all the legislative measures which are going to affect you in your practice of medicine. I am attempting to discuss a few of these measures which I believe you will find of interest.

Senate Bill 1221, and companion bill SB 723, were introduced to establish a committee to determine the health needs of the State of California. Many of you are aware of the fact that that is in actuality a C.I.O. bill and its many avowed objectives actually boil down to its one real but unstated objective of using a falsely created commission of the state to bring forth a report which will undoubtedly state, if such a commission were created, that all the forms of health care except compulsory health insurance are inadequate to meet the health needs of the people of California.

This measure has not yet been set for hearing and when it does appear you have our assurance that we shall do all within our power to oppose it.

AB 1159, which is more popularly known as a mental health bill, has passed the Assembly Committee on Social Welfare. Dr. Dwight Murray appeared before the committee in opposition to the measure as it was then written, and pointed out the very obvious fact that though it apparently has now arrived at a solution to the mental health problem of this state it was in fact no solution at all. He very ably presented to this committee the evident necessity for an intensive study of that problem and demonstrated that legislation should not be a substitute for an appropriate study.

The assistance of the California Medical Association in carrying out such a supervised study was offered by Dr. Merrill, certain socialistic proponents of the measure having toured California before in support of the measure. Many well-intentioned groups have, we feel, been taken into camp and have lent their support, believing that by a simple act of legislation the problems of mental health in California can be thus easily solved. It is the position of the California Medical Association that a very real problem exists in this field which merits thorough and careful study and to which study the California Medical Association will lend its entire support.

On this basis it has been our recommendation that this measure be referred to an interim committee for such study.

A decision possibly instigated by the State Department of Social Welfare was recently rendered by the Attorney General, which decision raised a question as to legality of participation by physicians and attorneys in any adoption procedure. To correct this situation a resolution was passed by this House of Delegates one year ago directing remedial legislative action. The Committee of the California Medical Association felt that a committee of the California Bar Association and a committee of social workers should be asked to attempt to compromise the commission's directive. The California Medical Association and the Bar Association representatives were in complete accord in their ideas, but these ideas were not acceptable to the social workers. Accordingly, legislation sponsored by the California Medical Association and by the California Bar Association was introduced which failed of passage. This failure was due in part to a report of a previous interim committee which studied this problem and recommended legislation such as we were requesting be not passed, and further based upon the apparent assumption on the part of the Assembly Judiciary Committee that this problem was not as real as it might seem.

Two bills were introduced to allow physicians the right to practice, one point being the establish-

ment of a Psychology Board under the Board of Medical Examiners.

Another simply establishing a Board of Psychology Examiners, to establish what are the requirements for admission. Neither bill has been set for hearing. The Board of Medical Examiners introduced four bills to modernize the Medical Practice Act and all bills are now on their way through the Legislature.

One bill now before the Legislature well demonstrates the necessity for having trained personnel constantly on watch over the 6,000 measures being introduced in Sacramento.

AB 3027, a measure to be heard before the Livestock and Dairy Committee, is a bill for the control of dogs running at large. One section of this bill, however, which is apparently a sleeper, or was meant to be, would make it a misdemeanor for the poundkeeper or any employees of the poundkeeper to release dogs to any person or institution for experimental purposes. This is obviously the old Anti-Vivisection Bill which has failed of passage before and its obvious attempt was hidden quietly in the measure to avoid scrutiny of the California Medical Association.

The naturopaths were back again with requests for a bill relating to the practice of medicine. After considerable stalling the proponents allowed this measure, AB 7, to be heard before the Public Health Commission. This measure was defeated.

I wish to express on behalf of your committee our appreciation to the many members of the California Medical Association who have so generously and readily responded to our various requests for assistance on the many phases affecting legislation before the Legislature. As you know, on various occasions your Legislative Committee presents to you a particular measure and you are asked to contribute your opinions in Sacramento. Your response has been most satisfactory and of considerable assistance to your committee in its attempt to protect your rights to practice medicine under a system of private enterprise.

On behalf of your committee I wish to thank our legal counsel, Mr. Howard Hassard, for the valuable assistance he has given to our committee and without whose help the effectiveness of your Legislative Committee would be markedly decreased. Also thanks to Mr. Ben Read, executive secretary of the Public Health League, whose constant diligence has each year so helped in protecting the members of this Association from the onslaughts of those who are not our friends.

Ben is extremely well liked and his counsel is trusted by our legislators.

In addition this year we have the very able services of Mr. Gene Salisbury, assistant executive secretary of the Public Health League, who comes into Public Health League affairs with invaluable experience in his former capacity as a representative of the California Hospital Association.

To Dr. James Doyle of Los Angeles go my thanks and the thanks of those connected with your legislative activity for the very fine work he has done as a member of this committee. Jim in his work in the southern part of the state has been of tremendous assistance. This assures a good legislative program. He has been a tireless worker and each task which he has assumed has been done well.

On the theory that the best should be saved to the last, I now wish to yield this floor to the chairman of the Committee on Public Policy, Dr. Dwight Murray.

SPEAKER CHARNOCK: Dr. Dwight Murray.

DR. DWIGHT H. MURRAY: Mr. Speaker, Mr. President, President-Elect, the time-honored Past Presidents of the California Medical Association, and members of the House of Delegates: You have heard something of what has been going on in the Legislative Committee in Sacramento. As usual it has been an active, busy session, and I don't see any prospects of its ever being less because for two sessions we have had about 6,000 bills, about 10 per cent of which have some application in some way to the practice of medicine and public health.

I want to tell you for a few minutes something about what is going on on a national plane. I think you might be interested in that. I think you should be interested. First of all, the President has embodied in his health program practically all the things which he wishes under the Omnibus Bill. The Omnibus Bill consists of six titles. Title 1 has to do with reinsurance; that is practically the same bill we had last year and the American Medical Association is opposing that bill. When the bill will be heard, we do not know.

Title No. 2 has to do with hospital financing. It is sometimes called the Wolverton and Kaiser bill. We feel that bill is probably the most vicious bill that we have and that it has to be opposed with all the might and power that the American Medical Association can get together.

I am asking Mr. Hassard to go and testify before the committee on this bill. We do not know when the hearing will be.

Title Nos. 3 and 4 have to do with the nursing profession. One has already been heard. Titles 5 and 6, particularly Title 6, have to do with Mental Health. The American Medical Association has advocated that we have a study commission, the same as you have heard advised for our own Mental Health bill in California. The problem is that all over the United States, and the psychiatrists recognize it, the problem for the care of the mentally ill cannot be adequately and properly met and they wish to do some research and study to try to get a plan and policy and procedure for meeting that difficult problem.

There are several other bills and I wish to say this to you, gentlemen, throughout the hearings it doesn't come out that they speak for federal aid for medical education but I hear this from some man sitting over here in the corner of the committee, "Well, doctor, how about this doctor shortage in the United States?" Somebody else will say,

"What about it, if we had more doctors in the United States couldn't they be spread out better, so that there would be no part of the United States that wouldn't be covered? Don't you think we ought to have some program by which we could graduate more medical students?"

Now of course you understand readily what would happen to a bill on medical education before men who are thinking that way. The President has stated, he stated to a very small group of us two years ago, that he was against federal aid to medical education but that medical education was our problem, and we must solve that problem.

Now he has never stated so far as I know whether he considers the problem is being adequately solved. There are several other bills of great interest to us. One is the selection of students on a scholarship basis. It is called the Medical Scholarship Bill, by which students who are regularly enrolled in a school of medicine will be given one, two, three or four years, with their bills paid, their tuition, all important things. In return they will give two years for one; that is, if they accept four years of education there will be eight years of service. That bill is to be heard very soon, I believe the 5th or 6th of May, very soon.

Then the Doctors' Draft Bill has been before the Congress, and as you know, Dr. Walter Martin appeared in opposition to the Doctors' Draft Bill. Now again we are confronted with this situation where some of the doctors of the country feel that the Doctors' Draft Bill should be passed because there has not been the proper selection of the doctors, and for that reason they are advocating the passage of the Doctors' Draft Bill. That is the situation. What will be the result, we do not know.

Another bill which you might be interested in, or at least you should be, is the Medical Aid for Dependents of the Military. That bill has not as yet been set for hearing but it is expected some time around the middle of May. Now a question has been asked of me, and many times, "What do you think about the situation in Washington, how is it, is it any better, any worse, is the President doing this, Mrs. Hobby doing that, how is it?"

Gentlemen, we have stayed with this plan and it is satisfactory to the American Medical Association, just as the California Medical Association will always adhere to the plan that whenever the administration violates the principles of your American Medical Association, or California Medical Association, then it will have to be opposed. It doesn't matter who, or what, who the president may be; it doesn't matter what the bill may be, we stand on principles that have guided us for many years and I can say to you that we are not seeking to oppose anybody at any time, but we are seeking to observe the principles of American medicine that have kept us strong all these years.

Now I could go on on several bills and several issues before the Congress at this time, but I think these are the things that are most alive and most pertinent to us at this time.

Now I have a statement to make to you, gentlemen, I am sure that will make you all very happy. On October 1, 1940, I was made chairman of the Legislative Committee of the California Medical Association. I am now resigning from the Legislative Committee of the California Medical Association. That will be, if I carry on until October, fifteen years, and I am sure that a great many of you would say that has been fifteen years too long; however, I wish to say that the affairs of the Legislative Committee are in good shape, as you can see from Dr. Dan Kilroy's report and by the reports of the other member of our committee, Dr. Jim Doyle, from Los Angeles. These men I feel are very capable; they have rendered very valuable service. Dr. Kilroy has been on the Legislative Committee four years, and I have recommended to the Council that Dr. Dan Kilroy be made my successor as chairman.

Now, gentlemen, there are a few things that I wish to say to you in resigning from this committee, things that I have noticed and things that I think may be of growing importance as time goes on. First of all I have noticed in the past fifteen years that there is a very decided increase in interest on the part of doctors generally in legislation. I can remember when the doctors didn't seem to know —they cared but they didn't seem to have a very direct interest about it—what was going on at the Legislature. There has been a very definite change in attitude. I find that doctors over the state are quite as well informed sometimes as the members of the Legislative Committee on many of these things; that is a very healthful sign and I am very happy to see it.

One thing that I do notice that has changed and that I am not so happy about, is a tendency on the part of groups or counties or various individuals going off on their own on legislative matters. Now that thing happens all too often and I would like to warn you about it. You will have some fast talker come to visit a county society and he will talk for or against a particular bill. He will show all of the various points, we'll say, for the bill. He will show for this reason, that reason, you should support it, "This is a grand bill," that will do that and that.

He never turns the coin over to see what is on the other side and too many county societies are apt to pass a resolution in favor of or against a bill without knowing the other side of the story.

Now oftentimes if a bill like that comes up, or if it is presented to you, first of all it is often the idea of the individual to show his interpretation of the bill. Don't take action on a bill until you have had an opportunity to see the printed bill and study it and then you can know from us; oftentimes your Legislative Committee or the Council will be able to guide you and tell you some of the background and some of the ins and outs.

The same thing is true, and I don't like to see that, with reference to different groups. Doesn't matter whether you are a surgeon or obstetrician,

or pediatrician, or orthopedist, or what you are, you are not as big as the whole. Remember that you are a part and not the whole of the California Medical Association, and the plan has been set up whereby you can go through channels, regularly constituted channels, to find out what is the best thing and how is the best way to approach it.

There is always a way that you can appeal and go to the Council of the California Medical Association, that is, before you take action. If you will do that, that allows us to present a united front. There is nothing more embarrassing than to go before a committee and say, "I am speaking for the California Medical Association. We have been authorized to speak for the California Medical Association by the Council on a particular bill." All right, we sit down and up comes Joe Doakes or somebody, who is just as good a member of the California Medical Association as you may be or anybody else may be, and he speaks in opposition. All right, then, what do the members of the committee think? They think, "Oh, well, you fellows had better go home and fight your own battles; don't come to the Legislature until you clean your own dirty linen." That is most embarrassing and a thing which should never exist. If you wish the Legislative Committee to carry on in an effective manner you will cease and desist from such actions, and I sincerely hope that is done.

I could speak of many things that I have noticed. I noticed with a great deal of satisfaction that there are a number of young men, I think younger than they were back when I was a delegate, and that bespeaks well. It is young men that we need, young men that need to train and learn about how is the best way to carry on, learn from these men over here, who have done well for many years.

I wish to thank very definitely this House of Delegates and the many other members of the House of Delegates, and members of the California Medical Association for their assistance that they have given me over these years. I think only about four or five times in all these fifteen years have I asked any member of the California Medical Association to do something that it hasn't been done and it is apparently done willingly and graciously and effectively. That is the thing that makes the Legislative Committee effective, and, gentlemen, I have appreciated that very much. I appreciate the assistance that the Council and officers of the California Medical Association have given me all through these years. These men who have been president here have assisted me no end.

The Council has never refused to assist in any way possible, financially or in any other manner, and done it readily. Now that is the thing that makes it worth while.

I want also to express my appreciation to the members of the Legislative Committee, to Dr. Dan Kilroy and Dr. Jim Doyle, as I have mentioned before. They have done very outstanding work and this is not a one-man show; although I have been accused of running a one-man show in Sacramento, it is not true. The many people who have assisted me, I have appreciated very much; Ben Read and Ed Clancy, and now we have in Ed Clancy's place Gene Salisbury and Dan Kilroy who have done very fine work.

Ben Read. Not too long ago I testified before a committee at the Legislature. I had an idea I had done a fairly good job; I didn't know but I was told so by different people. I heard afterwards that they thought, "Well, the California Medical Association wasn't much interested in this," that I was just putting up a little pitch here, the reason that the California Medical Association wasn't interested in it was because Ben Read wasn't there.

I got a great kick out of that and, gentlemen, that shows you how he is considered by the legislators. They call him "Doc," and when anybody gets sick in the Legislature he is called and then he in turn relays the calls to the doctors of Sacramento and I hope that the doctors of Sacramento continue with their very capable care of the members of the Legislature because that is quite important.

Ed Clancy used to receive very favorable comments from many members of the Legislature, giving reports to the legislators for use after they return home. It is impossible for a legislator to absorb everything that goes on, and then he'd go home and give this report. The only trouble was that sometimes two legislators brought in identically the same report to the same meeting. That was a little embarrassing, but that shows you what these men do and what they help along.

Gene Salisbury is carrying on very well, very effectively, is very well liked and I am sure will do well. Through all these years, though, we have been kept out of trouble repeatedly by our legal advisors. They have done a very good job in keeping us out of trouble and you know it is much easier to stay out of trouble than it is to get out after you get in. Likewise, before Mr. Hassard came here it was Mr. Peart who gave us such fine advice over many years and I can still see and hear him in the way he'd crack down on us on things that weren't right. Howard Hassard is following in the footsteps of a worthy leader.

I can't thank the staff of the California Medical Association, headed by John Hunton and Bob Thomas, enough; they have been imposed on by me many times. I hope that Dan Kilroy treats them more kindly than I have, but they have been asked many times to do things and I appreciate it very much.

Gentlemen, I want to say to you I have enjoyed this work very much, I have had a lot of fun. It has cost me a lot of time and cost me some money from my practice but I consider that it has been worth while. After all, we are all supposed to do something for medicine. I have no patience with a man who, when you ask him if he can do something up

at the county seat, will say, "I am busy, pretty busy." Where would he be if he hadn't had a medical society; where would he be if he hadn't graduated from medicine in the beginning? I have felt and still feel I owe a debt of gratitude to medicine and am doing my best to pay that debt and it has been a pleasure. My interest will always be in legislative affairs and I shall always be at the beck and call to assist in any way that I can. Thank you very much.

SPEAKER CHARNOCK: Thank you, Dr. Murray. The chair is going to call on Dr. John Cline.

DR. JOHN W. CLINE: I don't think really what I have to say now is superfluous. Perhaps few people have had the opportunity to work with Dr. Murray over as long a period and as closely as have I. Your reactions to his remarks as he sat down, having given his swan song before the House, I think were supremely eloquent, but in order to keep the record straight and in recognition of the tremendous service that Dr. Murray has rendered, not only to California medicine but to American medicine—and unless my predictions are wrong he will render ever greater service to American medicine before he is through—I wish to introduce a resolution. I am sure that the chair will have no objection to a resolution of deep gratitude to be expressed to Dr. Dwight H. Murray for his tremendous service to California medicine.

SPEAKER CHARNOCK: Thank you, Dr. Cline. Dr. Arlo Morrison will second the resolution. Dr. Morrison.

DR. ARLO A. MORRISON: Mr. Speaker, there are a few pleasant duties that we have with this office and I would like only to add, as John well knows, from my experience in the past two years, how much time and effort it takes to do a job as Dwight Murray has done. Dwight Murray was one of the first people I knew when I came into this organization in 1934 as a member of the House. I have appreciated his counsel, and we have been very, very close friends ever since. To me it is a great honor and pleasure to give to Dr. Murray this very small token of appreciation for the job you have done and to express my great personal esteem for your work in behalf of California medicine. This is presented to you, Dr. Murray, in appreciation of fifteen years of fidelity to medicine in California, and the whole nation. This is your pay for fifteen years of work.

DR. MURRAY: Thank you very much, gentlemen. This is a bit hard on your emotional equilibrium, but I assure you that I appreciate it. What I have done, if anything, for California medicine has been done very cheerfully and willingly and I am still your servant. Thank you very much. . . . Applause.

SPEAKER CHARNOCK: I am sure that the resolution has been adopted unanimously.

VICE-SPEAKER BAILEY: Next we hear from someone you have never seen before, Mr. Edward Clancy.

PUBLIC RELATIONS DEPARTMENT

MR. EDWARD CLANCY: Mr. President and members of the House of Delegates: Our report is one of the few made by nonprofessionals to the professionals. We are proud of the privilege, proud of the honor of representing the profession that has recorded so many accomplishments in making ever better medical care available to the public during the past twelve months. The concern of your Public Relations Department is how all your talents are conveyed to the public, how they are made available, how you have evidenced your interest in patients, and finally how your efforts are accepted.

Based upon the experience of our department we have every reason to believe that more doctors than ever before have come to the realization that the sum total of your public relations score depends upon the success of the public relations originating in each individual doctor's office. Said in another way, the care of the patient is not enough; success depends upon how well you convey to each individual patient that you care for him.

Doctors are showing this awareness; figures prove it. In the year 1954 our department made available to you a series of personal messages to be mailed to your patients. As you will remember they told your patients where you could be reached in an emergency, explained your willingness to discuss fees in advance of treatment, advised on prepayment of medical care in voluntary health insurance, and touched on the cost of good medical care, the danger of becoming a captive patient, and other related matters.

The doctors of California have ordered and mailed out 1,402,600 of these messages to their patients. The circular to gain interest in good medicine was distributed to 806,500 families; 227,210 health records have been distributed by the doctor to the mothers of their young patients. This altogether amounts to 2,436,000 pieces of literature stressing the importance of the doctor to the individual patient. That total is slightly more than those distributed by A.M.A. in serving the doctor. The office plaque reads: "To all my patients: I invite you to discuss frankly with me anything regarding my service or my fees. The best medical care is based on mutual understanding between doctor and patient," and this has been made available throughout the year. At present this forthright statement aimed at furthering better doctor and patient relationships for the elimination of misunderstanding is now on display in over 9,000 offices in California.

This total again goes further than that in the remaining 47 states. This display of the profession's interest in the patient's welfare, of the cooperation of the county society and our department, has been published in nearly every newspaper in the state. Since it furnishes one of the major barometers of our public relations activities, it may be noted that editors have saluted it in editorials. The press applauds the measures taken to effect medical care on a 24-hour basis, your willingness to talk about fees and willingness to present any patient's complaint

to the Public Service Committee (not Grievance Committee). Still using the press as a barometer, statewide, we see no more carping criticism of the profession and complaining to the editor or claims of libel.

In the realm of television, ten county societies have put on programs on a public service basis, with the station giving the time at no cost and the profession providing the panels. Two of the programs have received public service awards and in the thousands upon thousands of favorable comments these programs have generated, we know of but one complaint. It came from a husband who wrote, "Please do not start each program off with the medical insigne; my wife is afraid of snakes."

Routinely our department has been on call and at the service of all county societies and committees and commissions of the California Medical Association. We believe there has been an accelerated interest in the Physicians and Schools Conference. The press took great interest in rural health and the most active cooperation of the American Medical Association, based upon the success of the C.M.A.-sponsored Physicians and Schools Conference. Plans are now under way for regional meetings to foster better public relations with our equally sincere friends in the state educational systems.

Two Public Relations and Office Management conferences have just been held with students of the five medical schools, residents and interns, which are having excellent cooperation from the profession. Both the Los Angeles and San Francisco meetings were well attended. Discussion ran all the way from satisfaction in rural practice to the part the young doctor plays in civic affairs.

As a further service to the profession our department has issued a series of bulletins on current questions developed in the field of medical care plans and has produced tape recordings on this and other subjects for the use of county societies. It is the opinion of your department that this information, including professional announcements made available to county societies, should emphasize the local medical care services that are available.

These announcements should recite again and again the importance of every family having a personal physician in advance of any emergency. The announcements should contain a warning to read before subscribing to any medical care plans in which the services are limited to a few doctors.

We can, of course, continue to stress the basic principles that medical service be made available regardless of ability to pay and that people shall have it. In case of misunderstandings with physicians, the public may have access to the forum of public service committee, so that they may be resolved.

In connection with these programs we urge you to enlist the services of the Public Health League. These men can revitalize the story of the profession's past sacrifices and show that the hundred dollars per year dues were for the patient's protection, for the development of the protection of the public from the social battering ram of commercialized medicine.

Young doctors just starting to practice, foreign graduates and those transferring from other states should be made aware of what you more experienced men have done to maintain the free and unregimented practice of medicine for them.

With the proper background and education, we are certain, your new men will have a greater appreciation of their problems in your society. This we believe will be an important step in reducing the number of cases to come before your public service committees and the number of cases reaching the court house. Too often we have noticed in our many meetings with county societies many men have been announced as having been accepted for membership and have not taken the time to accept the honor.

Many other sound practical public relations programs have been outlined by your colleagues. This from a county society public relations chairman is a typical example to stress the importance of the part played by the individual physician. He is practicing "because of the very efficiency with which medicine is conducted today. It tends to impersonalize the relations of the patient with the doctor. As your efficiency increases new strides are made and a new course found and the time we need to spend with the patient decreases, so we must be increasingly aware of the fact we must counterbalance that with a growing concern over our personal relations with the patient. We must give adequate explanation, time and interest to the patient in his hour of trouble."

Finally, we must realize that the future of doctors and medicine rests not with the A.M.A., the state organization or the county medical society, but clearly in the hands of the individual practitioner of medicine. Only in so far as he approaches the ideal which we have outlined will the public relations of medicine remain strong and positive.

We wish to thank you, the members of the Council, and of the California Medical Association, county society officers, members of the Advisory Planning Committee and other members of C.M.A.'s executive personnel who have been of inestimable help really in guiding our efforts during the past twelve months. During that time our department has conferred with officers and members of each of the forty component county societies. One man today summed up a public relations discussion with a story about Zeke, a small farmer who was resting on his front porch after a hard day in the field. A neighbor came by to invite him to attend the meeting of the farm bureau. "What do they tell you at the meeting?" asked Zeke. "They teach you how to raise better grain, how to be a better farmer," his neighbor replied. "Why," Zeke answered, "that is sure a waste of time, I ain't farming as well as I know how right now." The moral, we believe, is obvious; public relations. I think we should all continue to attend the meetings of the farm bureau

in which they should make better and better public relationships.

On behalf of Mr. Glenn Gillette and myself, this report is respectfully submitted. Thank you.

VICE-SPEAKER BAILEY: Thank you very much, Mr. Clancy, for your report for the Committee on Public Relations, which will be referred to Reference Committee No. 1.

We will skip over a few items. I have been advised of no further reports, so we will get down to the Medical Services Commission, Dr. Hollis L. Carey.

MEDICAL SERVICES COMMISSION

DR. HOLLIS L. CAREY: Mr. Speaker and members of the House: I want to discuss resolutions first. That is why I handed in my copies to the secretary before I started to read.

During the past year your Medical Services Commission has held six meetings which, together with the activities of its various subcommittees, has made it a very active organization. I am dividing this report into sections devoted to the various subjects which we have considered.

1. *Uniform Claim Forms.* Following a request of this House of Delegates, a subcommittee, chairmanned by William Kaiser, M.D., of Berkeley, has been working toward the development of a single claim form which could be used in reporting claims for all types of prepaid indemnity insurance. The committee has been in close liaison with the California Committee of the Health Insurance Council, the insurance industry's organization, throughout its deliberations. The insurance industry has been working on this same problem for some time. The Medical Services Commission, the Health Insurance Council, and the Council of the C.M.A. have approved the use of two basic forms in reporting claims on indemnity medical care insurance. The commission felt that the single form requested by the House was economically unsound.

These two forms, one of which is to be used for reporting claims for persons having individual coverage, the other to be used for reporting claims where the subscriber is covered by group coverage, will furnish all information necessary for proper processing. Some insurance companies have not as yet indicated their willingness to accept these claim forms, but when the proper form is properly filled out and attached to the insurance company's own form there should be ready acceptance.

2. *Multiphasic Screening.* A subcommittee headed by Dr. Robert Shelton has seriously considered the subject of multiphasic screening. As you know, many nonprofessional groups feel that this is an excellent method of surveying segments of the population to evaluate the health status of that particular group. Your commission recognizes the defects inherent in this type of survey. However, we are also aware of the popularity of this procedure in certain areas. Multiphasic screening, as you know, is usually carried out with the cooperation of various organizations and usually consists of technical procedures that can be handled by technicians such as blood sugars, urinalysis, chest x-ray, electrocardiograph, etc., the results of which are interpreted by doctors. Your commission, while not yet convinced of the economy or medical value of multiphasic screening studies, recommends that so long as these studies can be carried out under the direction of the local county medical society and with the cooperation of the doctors of the area, the C.M.A. and its component societies offer their consultation and cooperation to those groups who wish to conduct such programs.

3. *Pilot Survey of Medical Costs.* A resolution introduced by Dr. Lester Lawrence at a previous meeting of this House requested that a factual survey of the actual dollars involved in the training of a doctor as well as the actual cost of conducting a typical medical practice be made. It was Dr. Lawrence's concept that no figures had ever been developed in this regard and that this would make a valuable contribution to the overall financial picture being considered in the fee structure of medicine today. Dr. Lawrence was appointed as chairman of this subcommittee on Medical Economics and was assigned the task of conducting such a survey. At the present time, the Medical Services Commission has appropriated funds and has employed the firm of Industrial Survey Associates to conduct a pilot survey in Riverside and Santa Clara counties to determine if such data can be obtained and the costs of such an undertaking. It is anticipated that final disposition of this phase of our work will be made as soon as these initial undertakings are accomplished.

4. *Regional Health and Welfare Conferences.* During the past year, the Institute of Industrial Relations, U.C.L.A., and the Health Plan Consultants Committee of Los Angeles, representing labor unions, have held a series of five health and welfare conferences in various areas of the state. It was their intent to study and evaluate the field of prepaid medical care and to disseminate such information to their membership. Representatives from the Medical Services Commission attended each of these meetings and actively assisted the county medical societies where these meetings were held.

5. *Fee Committee.* The Executive Committee of the California Medical Association has reaffirmed the action of the House of Delegates taken in 1946 in stating that "The Board of Trustees of California Physicians' Service shall revise the fee schedule biennially, this revision to be made upon the recommendation of a committee appointed by the Council of the California Medical Association. The Fee Schedule Committee of the Medical Services Commission at present serves this purpose and reports its action to the commission, and through it, to the Council for transmittal to the Board of Trustees of California Physicians' Service. The Board of Trustees of California Physicians' Service has final authority in adopting a fee schedule."

This group is our most active committee. I should like to inform you of this committee's assignment and the techniques used by the committee in carrying out its work.

Since August 1952, the California Medical Association has repeatedly expressed the need for study of an evaluation of the relative money-value of one medical service to another. For instance, if an appendectomy is worth x dollars, how much added to x would constitute a reasonable fee for a hysterectomy? To the best of our knowledge, no definitive study of this problem has ever been made.

On March 10, 1953, the Medical Services Commission of the California Medical Association appointed a subcommittee on Principles of Fee Schedules in order to develop this information, the purpose of which was to bring order out of several varieties of chaos:

1. The chaos of some 22 separate county medical society fee schedules, no two of which contained similar procedures or similar nomenclature and which were, therefore, not useful from a statewide point of view.

2. The chaos of private insurance company fee schedules, which express no rational relationship between fees because for at least twenty years insurance companies have been developing their fee schedules either by copying them from each other, or with a view to hiding insurance defects behind a façade of high payments for procedures rare but not necessarily difficult.

Such information will also assist in continuing the improvement of C.P.S. fee schedules.

In order to save money and effort, the committee first tried to develop a statewide fee relationship from the mass of information available in the 22 county fee studies. Because of the variations in techniques, nomenclature and numbers and types of procedures, we were forced to abandon this technique and to make our own survey, using the standard nomenclature of Blue Cross and Blue Shield.

After developing a survey questionnaire, we started with a pilot survey in Orange and Sacramento counties, in order to make our mistakes on a small but representative scale. We reported what we learned, and were given $15,000 with which to conduct a statewide survey.

Forty-seven hundred California physicians responded to this survey, and their information was transcribed to IBM cards. An established statistician, recognized for his work in medical economic research, came to California to consult with us, and after careful examination, he assured us that our information and sample were adequate and worthy of statewide application.

With the assistance of the consulting actuary firm of Coates, Herfurth and England, we tested this assurance with a statistically valid number of procedures which in the aggregate accounted for from 90 per cent to 95 per cent of all payments to doctors. These procedures were run through the machines again, first on the basis of each individual county and second on the basis of a division of counties into ten geographical groups. A very high correlation developed from these tests when we compared the median fees charged in each county and each geographical group with the median fee charged statewide. We applied other more detailed tests, and because of the close correlation achieved, we felt that development of a statewide relative value fee schedule for the state as a whole was statistically justified.

Most of the procedures listed in the study originated in the survey, which was prepared with a view to eliminating obsolete procedures and adding new and more recent procedures. Your committee feels that the study now reflects with accuracy the actualities of the practice of medicine in California today. The additions were recommended to your committee by doctors representing each field of medical practice, together with the relative values they suggested should be assigned to each procedure they added. Where more than one specialty made differing recommendations as to the relative value of a procedure, the committee named a figure after consideration of all arguments.

We have been confronted with the proposition that we should make two relative value studies, one for general practitioners and the other for specialists. To forestall this proposition, may we say that this has been discussed by your committee, which considers such a proposal unworkable and not in keeping with the assignment of this committee. There are a number of reasons for this which became clear upon consideration.

To forestall any doubts we should say also that this study has nothing to do with recommending or setting anyone's fees. Nor are the results of this survey permanent. When it is necessary to do so, C.P.S. and other insurance carriers may be informed of such necessity, and this committee is the logical study group which should evaluate and expedite such changes.

We hope that this study will be used by insurance companies in setting their indemnities, and that C.P.S. will use it in setting its payments, and that insured groups will use it to measure the sensibleness of the coverage for which they pay their premiums. We hope that it will make good, adequate insurance, which allows free choice of doctors, easier to produce, buy, sell and administer. We hope that it will be used to eliminate some of the obvious inequities in all fee lists, and that it will establish the exclusive right and the exclusive duty of medicine to set and interpret its fees and the methods by which doctors will be paid. And, with a great deal of continuing study and revision, we hope it will help make available to each doctor his fair proportion of the medical dollar spent in California.

We have minor details yet to complete in our work. This consists of further consultation with doctors representing various branches of medical practice and final minor corrections.

The committee has adopted two primary principles:

1. That a dual schedule of fees cannot serve the best interests of medicine at this time.

2. That an interrelationship between medical fees can be established which can create a schedule of relative values that can be applied statewide.

I should like to personally thank Francis J. Cox, chairman, DeWitt K. Burnham, James B. Graeser, Howard P. House, Henry A. Randel, Orville W. Cole and Leon O. Desimone for the fine work done to date.

6. *Usual Fee Indemnity Plan.* You will recall that in its report to the House of Delegates last year, the Medical Services Commission brought out the fact that personalized, high quality medical care that only the individual practitioner of medicine could render was our best product; and the basis by which this better product could be built was the ethical consideration that "the welfare of the patient is the first concern of medicine." The challenge is for the profession to provide personalized, high quality medical care at a cost which the patient can reasonably determine in advance of receiving the service. This plan, now familiar to you and known as the Usual Fee Indemnity Plan, embodies these basic concepts.

The commission realized that it would take time to educate the public and the profession in the principles of the Usual Fee Indemnity Plan. We continue to urge each county medical society to give this concept serious consideration.

7. *Deductible Insurance.* The commission has held two meetings in which we have considered new and unusual types of deductible indemnity insurance. Certainly there are many features of this type of plan which are quite attractive. However, we are not yet ready to make specific recommendations on this type of coverage. We encourage those companies now experimenting and are hopeful for their success. This type of plan will be considered further by your commission.

8. *Indigent Care Program.* One of the most interesting subjects the commission has considered this year has been the possibility that the medically indigent patient might possibly be cared for under a prepaid insurance plan. Your commission has some most interesting information on this subject. In the state of Washington such a plan has been in progress for the past five years. The Board of Trustees of California Physicians' Service has been informed of these studies and is cooperating with the commission in this phase of our work. A very small area in this state has, for the past three years, had an ambulatory office type of care for the indigents of its area. The figures from this small area suggest that the medically indigent patient can be taken care of on a prepayment basis much more economically than under the present systems.

The commission approved in principle the idea of having C.P.S. negotiate with the administrative and/or executive bodies of any of the counties of the state regarding the provision of medical care for the certified indigent or "medically indigent" members of C.P.S., with the view that such care, provided locally by the patient's personal physician, might be a more effective and more economical arrangement than automatically sending such patients to the more impersonal county hospitals and clinics.

The commission has requested the Council of the C.M.A. to urge the C.P.S. Board of Trustees to study the feasibility of such a program, and to negotiate with the responsible county officials in any county in which the county medical society requested such action. All county medical societies should be advised of the existence of this opportunity.

I wish to take this opportunity to thank all of the members of the Medical Services Commission who have willingly given their services during the past year. In addition, I would like to thank Roy Hamman, executive director of California Physicians' Service, for his untiring and patient efforts on behalf of the doctors of California. I feel that he has brought to us a wide experience and mature judgment seldom found in one individual. He has, at all times, made available to us personnel and material from his organization whenever and wherever it was needed.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Carey. The chair recognizes the immense amount of time and conscientious endeavor which has just been represented. We assure the entire committee of the gratitude of this House for their efforts.

We have a report from Dr. Dwight Murray on the Committee of Public Relations. Dr. Murray.

DR. DWIGHT H. MURRAY: Mr. Speaker, members of the House: The Committee on Public Relations consists of the President, President-Elect, Secretary of the Association and the chairmen of the Committees on Public Policy and Legislation, Associated Societies and Technical Groups, and Medical Economics, plus two others named by the Council of the Association. The Secretary serves ex-officio. This committee met on March 26 and the following report is submitted.

During the Association year now drawing to a close the committee has been asked to review the public relations activities of the Association with the particular purpose of ascertaining whether or not there is an overlapping of authority, responsibility, activities or finances. This review has involved looking into three separate activities. One, the Public Relations Department of the Association. A second is the programs being administered by Rollen Waterson Associates, and the third is the California Physicians' Service. In reviewing these three programs the committee secured detailed reports from Mr. Ed Clancy, director of Public Relations of the C.M.A., Mr. Rollen Waterson and Mr. K. L. Hamman, executive director of California Physicians' Service.

The program headed by Mr. Waterson includes for the main part the promotion of voluntary forms of health insurance which permit free choice of physicians and hospitals.

Under the proposals approved by the 1954 House of Delegates this endeavor has been pretty well confined to two fields. First is the promotion of the usual fee indemnity plan and second is the dissemination of information about the voluntary local option plan for California Physicians' Service to establish a $6,000 ceiling program.

In view of the period of time required to work up the usual fee indemnity plan and make it effective in any community, the establishment of the $6,000 C.P.S. ceiling has appeared to be the only program which can conceivably be put into effect at this time to offer competition with closed panel programs. Consequently, Mr. Waterson's activities have been mainly in this field, but have not been limited in such a way as to neglect the promotion of the usual indemnity concept or the necessary market research into public needs and desires in health insurance.

The Usual Fee Indemnity Plan has been adopted in some four counties and has been offered in several other counties where no action has been taken. I might say that this plan is being very closely watched and I have been asked many questions by men from other states as to how successful it is and they are watching as usual what California is able to do with it.

On the other hand, many county societies have requested information on the $6,000 C.P.S. ceiling. As of a month ago, that is, about the first of March, 27 counties had embraced this program. These counties cover about one-fourth to one-third of the population of California. Mr. Waterson was granted a budget of $183,000 for these activities in the meeting of the House of Delegates last year. In the first eight months of the year he had spent in round figures some $39,000 and had in process another $10,000 of work which had been approved by the C.M.A. Executive Committee.

It is estimated that by the close of this fiscal year next June 30, his total expenditures for the 14-month period will come to about $75,000, possibly less.

California Physicians' Service has been operating on a budget of $60,000 a year for sales promotion. For the coming year the budget has been increased to $75,000. These funds are spent for newspaper advertising, production of pamphlets and similar means of attracting both employees and management to consider C.P.S. as a health insurance carrier. When it is considered that C.P.S. is doing a gross business of $25,000,000 a year, the expenditure of $75,000 represents only three-tenths of one per cent of the gross, a figure which is surprisingly small when you consider it alongside the importance of maintaining the membership.

C.P.S. has not embarked on any program of either public or professional education except in maintaining a staff of physician relations personnel to serve the physician members throughout the state and to answer questions and in general represent the organization to its own physician members.

It is not engaged in any of the public relations activities which are generally thought of in terms of publicity, institutional advertising, and so forth.

The Public Relations Department of C.M.A. has devoted its efforts to the fundamental effort of promoting and fostering sound physician-patient relationships. Much of that work follows the suggestions laid down by Dr. Ernest Dichter several years ago. This work has involved the establishment of emergency telephone service, dissemination of information about individual physicians to their own patients relative to their availability to the community and similar projects.

I think, gentlemen, we can all testify to the fact that this has helped us immensely and has given us really a mark of progress for the California Medical Association and certainly it has improved our relations with the public no end.

In the past six months the Public Relations Department has been called upon by members of the Association for about 1,500,000 pieces of literature for distribution to their patients. These items are sent on request of a member. The C.M.A. Public Relations Department was granted a budget of $85,000 at this time last year. In the first eight months of the fiscal year its total expenditure amounts roundly to $42,000 and it is estimated that by the end of the fiscal year the total will come to around $55,000.

You have just heard a very excellent report from the Director of Public Relations Committee on his activities, and, gentlemen, I can say that the work that that committee has done is bearing fruit every day. I think it is a fine piece of work that they have done and as you will see later on, we recommend its continuing.

In reviewing these functions and activities the committee was of the opinion there was no overlapping of the functions, or programs of expenditure. The committee also felt that the C.P.S. sales promotion program was strictly a business promotion plan. These activities should not be further considered by this committee but left in the capable hands of the Trustees of C.P.S.

In accordance with this belief, the balance of this report will deal with the functions of the C.M.A. Public Relations Department and Rollen Waterson Associates. The committee gave considerable thought to the broad subject of public relations and came back to the fact which has long been recognized, namely, that public relations for the medical profession originates in each physician's office in his dealing with his patients.

In this concept it is obvious that good public relations in the profession requires top performance by each physician and such performance requires a considerable amount of indoctrination of physicians. Such indoctrination must cover not only new

graduates in medical schools but also the thousands of physicians who come to this state each year by reciprocity and are not familiar with California conditions and needs. While some efforts are now being made in this direction the committee will offer additional suggestions as part of its recommendations.

Conclusion 1. The committee finds no overlapping or duplication in the public relations program of the C.M.A., C.P.S. and Rollen Waterson Associates.

Conclusion 2. The committee sees opportunity for greater correlation of these programs.

Conclusion 3. The committee suggests that the C.P.S. Public Relations and Sales Promotion program be disassociated in our thinking from other programs since C.P.S. is primarily concerned with selling contracts and not with molding basic public opinion.

Conclusion 4. The committee sees the need for gradual development of indoctrination programs to cover all physicians. I think that should be stressed very strongly. We find these boys just graduating from medical school where they go into hospitals for intern and resident training, come out with very little conception of just generally what is required of a doctor in private practice and I think it is up to each individual county society to see that these boys are properly indoctrinated at the time they are accepted into the society.

I understand that Los Angeles County has long since been involved in such a program and I am told by many of the members that it is a very helpful thing.

Conclusion No. 5. The committee feels that the basic public relations work of the C.M.A. Public Relations Department must be of a continuing nature. The need for more fully trained physicians in this field will continue for an indefinite period. The question was brought up in discussion between the members of the committee and those who were interviewed at that time, would it be possible for this work to be turned over to physicians alone. We felt that it would be highly desirable but to find the physicians who were capable and who were willing to do this work is quite another thing. We felt that it is being very carefully and conscientiously carried out by your doctors at the present time.

Recommendations of the Committee on Public Relations

1. That the campaign of fundamental public relations now being undertaken by the C.M.A. Public Relations Department continue, with adequate supervision by the appropriate committees and the policy-making bodies of the Association.

These committees cannot carry on in the way that you want them to unless a policy is first laid down and I think if there is any fault to find with any of the committees that it has been due to the fact that they have not had the proper instruction or probably the proper policy has not been laid down for them to follow.

2. The committee suggests that means be found to provide a more adequate and meaningful indoctrination program for physicians, whether they be recent medical school graduates or physicians coming from other areas into California.

As you know, there are many physicians coming to California from other states. I was told by the Board of Medical Examiners not too long ago, possibly three months ago, that there were around 1,300 doctors that had come in the past year from other states. They have practiced in other states, to be sure, but their concepts and their knowledge of the average needs are different somewhat to California. You know, being a little egotistical somebody has said, "If you want to know how the world is going to look in 25 years look at California now."

3. That means be found more fully to impress on all the physicians the fact that professional licenses carry with them a responsibility to the community. Each licensed physician has a duty and responsibility which he can make effective as a participant in community and civic affairs. I think that cannot be stressed too much, gentlemen, because we must be citizens of our community. If we are citizens of our community I am sure the community will respect us much more highly. Let's get in and help the Chamber of Commerce and help everybody we can and we can do a lot of work toward influencing such things as the Tuberculosis Association, Cancer Society and many others that need direct professional leadership.

4. That the program of the Association be continued along its present lines under the supervision of the C.M.A. Executive Committee and Council as long as a need for this work continues.

5. That a continuing correlation of the activities of the three groups now under study be fostered by all concerned and in the case of C.P.S. this correlation will result in closer cooperation between the C.M.A. representatives, and the professional service representatives of C.P.S.

6. That the overall supervision of the Public Relations activities be maintained under the present committee set-up of the C.M.A. or under such amendments as may be approved by the House of Delegates.

The committee wishes to thank those who appeared before it and contributed information essential to this study. It also wishes to commend those counties which have embraced the Usual Fee Indemnity Plan and thus have embarked on the long-range program of a voluntary form of health insurance with free choice of physicians. The committee also wishes to commend the county societies which have developed the $6,000 C.P.S. Income Ceiling Program and thus made possible the medical offering of free choice health insurance contracts in this area.

This report is submitted by the Committee, Dr. Arlo Morrison, Dr. Sidney J. Shipman, Dr. Frank A. MacDonald, Dr. H. Gordon MacLean, Dr. Leopold H. Fraser, Dr. A. C. Daniels, ex-officio, and the chairman. Thank you.

VICE-CHAIRMAN BAILEY: Many thanks, Dr. Murray, to you and the many members of your committee. Are there any further reports of officers or standing committees, special committees?

INTRODUCTION OF RESOLUTIONS

That brings us up then to Unfinished Business, of which the chairman knows of none, and thus to New Business. Under New Business the Council has not called an interim session, thus such resolutions as are presented shall be acted upon at this session. We call your attention to the C.M.A. custom of allowing resolutions to be presented only as the resolved portion, with no "whereases" in the beginning to explain it.

Your Speaker and Vice-Speaker feel a minimum amount of argumentation before the resolved part is given is to the benefit of the House because we then have a better knowledge of what the resolution is about. We hope there is not too much explanation because the proper place for such explanation is in the Reference Committee. Are there any resolutions? Dr. Lum.

DR. DONALD D. LUM: I will introduce these resolutions from the Council.

BY-LAWS AMENDMENT No. 1

Resolved, That Chapter VII of the By-Laws of this Association, California Medical Association, is hereby amended by deleting the present Chapter VII and inserting in lieu thereof the following:

Chapter VII—Commissions and Committees.

Section 1. Commissions and Standing Committees.

This Association has the following commissions and standing committees that are subordinate to the respective commissions as follows:

(a) *Commission on Medical Services*, responsible for the activities of and through which the following standing committees shall report: (1) Committee on Medical Economics, (2) Committee on Fees, (3) Committee on Maternity and Child Care, (4) Committee on Indigent, (5) Committee on Problems of the Aged.

(b) *Commission on Public Health and Public Agencies*, responsible for the activities of and through which the following standing committees shall report: (1) Committee on Rural and Community Health, (2) Committee on School Health, (3) Committee on Military Affairs and Civil Defense, (4) Committee on State Medical Services, (5) Committee on Veterans Affairs.

(c) *Commission on Public Policy*, responsible for the activities of and through which the following standing committees shall report: (1) Committee on Legislation, (2) Committee on Public Relations.

(d) *Commission on Medical Education*, responsible for the activities of and through which the following standing committees shall report: (1) Committee on Medical Education and Hospitals, (2) Committee on Mental Health, (3) Cancer Committee, (4) Committee on Postgraduate Activities, (5) Committee on Blood Banks, (6) Committee on Industrial Health and Rehabilitation.

(e) *Cancer Commission*, responsible for the activities of this Association in the fields of cancer research, prevention, education and control.

(f) *Commission on Professional Welfare*, responsible for the activities of and through which the following standing committees shall report: (1) Committee on Health and Accident Insurance, (2) Committee on Unlawful Practice of Medicine, (3) Medical Review and Advisory Board.

(g) *Judicial Commission*, which shall hear and decide all appeals of disciplinary actions taken by component societies in the manner and as provided in Chapter III of the By-Laws.

Section 2. Standing Committees—Creation of New or Termination of Existing Committees.

The Council, on recommendation of a commission, may create new or terminate existing standing committees that are to function or function under the commission submitting the recommendation.

Section 3. Commissions—Membership—Method of Appointment and Terms of Office.

Unless otherwise provided in these By-Laws, each commission shall consist of not less than five nor more than nine members; the number of members of each commission to be determined by the Council from time to time.

Members of the commissions of the Association shall serve for terms of three years, and to the extent possible terms of office of commissioners shall be staggered. Terms of office shall expire at the close of the annual session of the Association, and prior to each annual session the Council shall nominate successors to those commissioners whose terms will expire and submit the names of such nominees to the House of Delegates. The House of Delegates may confirm or reject any nominee. If the House rejects any nominee, the Council shall immediately submit another nominee.

In nominating commission members the Council shall endeavor to maintain on the membership of each commission the chairmen of the committees that are subordinate to and report through such commission.

Vacancies occurring between annual sessions shall be filled by the Council.

Section 4. Judicial Commission.

The Judicial Commission of this Association shall consist of nine members, who shall serve for terms of three years each and who shall be appointed by the Council. The terms shall be staggered so that three terms expire each year. Terms expire at the conclusion of the annual session. Its jurisdiction and powers shall be as set forth in Chapter III of the By-Laws.

Section 5. Standing Committees—Membership—Appointment and Terms of Office.

Unless otherwise provided in these By-Laws each of the standing committees listed in Section 1 of this Chapter shall consist of not less than three nor more than nine members; the number of members of each standing committee to be determined by the Council. Members of standing committees shall serve for terms of three years each. One-third of the membership of each of these committees shall be nominated annually by the Council, subject to confirmation or rejection by the House of Delegates. If the House of Delegates rejects any nomination, the Council shall immediately submit another nominee.

Vacancies occurring between annual sessions shall be filled by the Council.

Section 6. Procedure for all Committees.

Commissions, standing committees and special committees of the Association may make investigations and surveys on authorization of the Council or House of Delegates; but all recommendations and reports of standing committees shall be submitted to the commission under which each standing committee functions and all reports of commissions shall be submitted to the Council or House of Delegates.

Other than as herein stated, no committee is authorized to act for or bind this Association.

Section 7. Officers of Commissions and Standing Committees.

The chairman of each commission and of each standing committee shall be appointed from among the membership of each commission and standing committee annually by the Council, by and with the approval of the House of Delegates.

Each commission shall have a secretary, who shall likewise be appointed annually by the Council, by and with the approval of the House of Delegates.

Each standing committee may but need not have a secretary, and if it determines to have a secretary it may elect one of its own members to such office.

Section 8. Annual Reports.

Each standing committee shall submit a written report to the commission under which it functions, as and when required by it. Prior to the annual session each commission shall submit a written report to the Council, including therein the reports of the various standing committees for which each commission is responsible. The Council shall determine in each year the time when such reports shall be submitted.

Section 9. Duties of Commissions and standing Committees.

(a) The *Commission on Medical Services* shall study, investigate and from time to time submit recommendations concerning the methods under which medical services are furnished or organized and concerning all phases of medical economics. It shall allocate to the various standing committees for which it is responsible particular projects within their respective fields.

(b) The *Commission on Public Health and Public Agencies* shall study, investigate and from time to time submit recommendations concerning public health matters and the activities of public agencies in the field of medical care. It shall allocate to the various standing committees for which it is responsible particular projects within their respective fields.

(c) The *Commission on Public Policy* shall study, investigate and from time to time submit recommendations concerning legislative matters affecting public health or the practice of medicine and concerning relations between the public and the medical profession. It shall allocate to the various standing committees for which it is responsible particular projects within their respective fields.

(d) The *Commission on Medical Education* shall correlate the activities of the various standing committees for which it is responsible in their specific fields of medical research and study and education; it shall from time to time submit recommendations and reports concerning activities within the functions of its standing committees. It shall allocate to the various standing committees for which it is responsible particular projects within their respective fields.

(e) The *Commission on Professional Welfare* shall study, investigate and from time to time submit recommendations concerning professional welfare. It shall allocate to the various standing committees for which it is responsible particular projects within their respective fields.

Section 10. Committee on Scientific Work.

There shall be an independent standing committee on scientific work consisting of the secretary-treasurer, secretaries of the sections on General Surgery and General Medicine, and three other members appointed by the Council, each of these three members to serve for terms of three years, one member being appointed each year. The secretary-treasurer shall be chairman of the committee.

This committee shall determine the character and scope of the scientific proceedings of the Association for each session, and shall invite the guest speakers, subject to the instructions of the Council.

At least thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers and discussions shall be presented.

This committee shall also act as the Committee on Arrangements for the annual session. It shall have charge of all local arrangements not otherwise provided for. It shall provide suitable meeting places and shall have general charge of all local arrangements. It shall have power to appoint local advisory members and subcommittees to aid in its work.

This committee shall have at least one joint session with the section secretaries, at a time and place to be designated by the chairman of the committee, at least forty-five days prior to the annual session, to coordinate more efficiently the various activities of the Association at its annual session. The chair-

man of the local committee on arrangements shall be invited to attend this meeting.

Section 11. Publication of Commission and Committee Reports.

Reports of the commissions and their standing committees and reports of special committees, as approved by the Council, shall be published in a pre-convention bulletin or in the official journal.

Section 12. Special Committees.

The House of Delegates and the Council are authorized and empowered to appoint special committees, with special instructions as to work to be undertaken, whenever it is deemed necessary to do so.

Special committees shall report as directed in the resolution or action creating them.

Each special committee shall report at the annual session immediately following its appointment, and unless it is continued by action of the House of Delegates or Council its existence shall terminate at the close of the annual session to which it reports.

And Be It Further Resolved, That Chapter VI, Section 6(c), of the By-Laws of this Association is hereby amended by adding at the end of said subsection (c) the following new sentence:

"It shall act as an advisory committee to the Editor."

And Be It Further Resolved, That Chapter III, Sections 2 and 3, of the By-Laws of this Association, are hereby amended by substituting the words "Judicial Commission of this Association" for the word "Council" in all places where said word "Council" appears; by substituting the words "Secretary of the Judicial Commission" for the words "Secretary of this Association" in Section 2; and by deleting the words "Executive Committee or" from Section 2.

And Be It Further Resolved, That Section 6 of Chapter IV of the By-Laws of this Association is hereby repealed.

VICE-SPEAKER BAILEY: This will be a proposed By-Law change and therefore referred to Reference Committee No. 4.

DR. LUM: The next two resolutions are concerned with Physicians' Benevolence Fund.

CONSTITUTIONAL AMENDMENT No. 1

WHEREAS, A new corporation has been established called Physicians' Benevolence Fund, Inc., to administer the duties under Section 6 of Article IV of the Constitution of the California Medical Association; now, therefore, be it

Resolved, That Section 6 of Article IV of the Constitution which now reads:

"At least $1.00 out of the annual dues paid by each active member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the By-Laws."

is hereby amended to read as follows:

"At least $1.00 out of the annual dues paid by each active member of the Association shall be allocated to the Physicians' Benevolence Fund, Inc., a corporation, and shall be used for the purposes as set forth in that corporation's Articles and By-Laws."

BY-LAWS AMENDMENT No. 2

WHEREAS, A new corporation has been established called Physicians' Benevolence Fund, Inc., to administer the duties under Section 18 of Chapter VII of the By-Laws of the California Medical Association; and

WHEREAS, The functions as set forth in Section 18 of Chapter VII of the By-Laws of this Association, California Medical Association, are no longer necessary; therefore be it

Resolved, That Section 18 of Chapter VII of the By-Laws of the California Medical Association be and is hereby deleted from said By-Laws.

VICE-SPEAKER BAILEY: That also will be referred to Reference Committee No. 4.

DR. LUM: Constitution and By-Laws.

BY-LAWS AMENDMENT No. 3

WHEREAS, Section 18 of Chapter VII of the By-Laws of California Medical Association has been deleted; and

WHEREAS, It is desired for the maintaining of the continuity of the remaining sections of Chapter VII; now therefore be it

Resolved, That Sections 19, 20 and 21 of Chapter VII of the By-Laws of the California Medical Association be renumbered as Sections 18, 19 and 20 respectively.

VICE-SPEAKER BAILEY: Same committee. Thank you.

DR. LUM: This is a resolution concerning Immune Globulin (Human).

RESOLUTION No. 1

WHEREAS, "Immune Globulin (Human)" has been dispensed under that name for many years, for use with a variety of conditions; and

WHEREAS, This same product has now been labeled by the National Institutes of Health under the official nomenclature "Poliomyelitis Immune Globulin (Human)" under the licenses granted to biological laboratories; and

WHEREAS, The inference of the new nomenclature is that this preparation is specifically a product for the treatment of poliomyelitis; and

WHEREAS, The Council on Pharmacy and Chemistry of the American Medical Association, as well as producers of this product, are opposed to this new nomenclature; now, therefore, be it

Resolved, That the California Medical Association go on record as requesting the change in name of this product to its earlier designation; and be it further

Resolved, That the California delegates to the American Medical Association introduce and work for the passage of a resolution in the House of Delegates of the American Medical Association to bring about this change of name.

VICE-SPEAKER BAILEY: That goes to Reference Committee No. 3. Thank you, Dr. Lum, for the Council's resolutions.

For further resolutions we ask that you give your name and county for the benefit of the record here. Any other resolutions?

DR. HOMER C. PHEASANT (Los Angeles County):

BY-LAWS AMENDMENT No. 4

Resolved, That Chapter IV, Section 1(a) of the By-Laws be amended by adding "Orthopedics" to the list of Scientific Sections and by changing the number of Scientific Sections from fifteen to sixteen.

VICE-CHAIRMAN BAILEY: That goes to Reference Committee No. 4.

DR. EDWARD C. HALLEY (Fresno County): My resolution concerns charges for hospital service.

RESOLUTION No. 2

WHEREAS, The public has become critical of increasing hospital charges; and

WHEREAS, The increasing costs of hospital services is one of the major reasons for many people demanding state medicine; and

WHEREAS, It can be shown that the subsidization of hospital board and room costs by income from other hospital services is in fact exploitation of private uninsured patients and is also a subsidization of industrial and commercial cases; and

WHEREAS, This uncorrected practice is against public policy and honest medical ethics; and

WHEREAS, "The basic principle in establishment of charges should be that each department be self-supporting and so applied that neither the hospital nor the physician rendering the service shall exploit the patient or each other"; now, therefore, be it

Resolved, That the California Medical Association place upon record that it believes hospital charges should be lowered where possible; and be it further

Resolved, That the actual cost of room and board be reflected in hospital charges so that charges for other services need not be exaggerated in order to cover deficits incurred by inadequate charges for room and board; and be it further

Resolved, That a copy of this resolution be officially transmitted to the California Hospital Association urging and encouraging that association to help correct the existing situation as to charges for hospital services.

VICE-CHAIRMAN BAILEY: Thank you, Dr. Halley. That will be referred to Reference Committee No. 3. Dr. Malcolm Todd.

DR. MALCOLM TODD (Los Angeles County): I have a resolution in behalf of the Ophthalmological Section.

RESOLUTION No. 3

WHEREAS, A committee of three members of the Ophthalmological Section of the American Medical Association has advised the Judicial Council as a basis for a ruling that it is unethical for a physician to dispense glasses unless there are no other sources from which the patients can obtain the glasses in that locality; and

WHEREAS, The thousands of individual ophthalmologists who are members of the American Medical Association were never consulted regarding their opinions and desires in this matter; and

WHEREAS, From the time the American Medical Association was founded the members have possessed the freedom of rendering complete dispensing services to their patients; and

WHEREAS, Many ophthalmologists sincerely and conscientiously believe that in their individual practices the best interests of the patient are served by the ophthalmologists rendering complete dispensing services; and

WHEREAS, The dispensing of glasses is not primarily the selling of merchandise, but is primarily the rendering of a service; and the furnishing of the merchandise is only incidental; and

WHEREAS, The American Optometric Association has passed a resolution stating that the "field of visual care belongs exclusively to optometry and that it is the stated objective of the American Optometric Association that all other professions who engage in the field of visual care should be excluded from this field by the enactment of new statutes in all of the various states"; and

WHEREAS, Any such action would entirely exclude ophthalmologists from the field of refraction and eventually from the care of any eye condition or eye disease, and would even prevent a physician from recording a patient's visual acuity; and

WHEREAS, Any interpretation of ethics which prevents an ophthalmologist from rendering a complete dispensing service tends to force many of his patients into the hands of the optometrists and works for the attainment of optometry's stated objective of excluding ophthalmologists from the field of visual care and the taking over of the field of ophthalmology by the optometrists; and

WHEREAS, There should be no further infringement on the basic individual freedoms of ophthalmologists nor of any other group of the members of the American Medical Association; and

WHEREAS, A recent poll of all physicians practicing ophthalmology in Los Angeles County, taken by the members of the Los Angeles Society of Ophthalmology and Otolaryngology showed that the ophthalmologists were in favor of permitting each physician to render a complete dispensing service if he

wished to do so, by a ratio of 183 to 10; therefore, be it

Resolved, That the House of Delegates of the California Medical Association instruct the California delegates to the American Medical Association to reopen the discussion, and actively work for a change of the present interpretation regarding the ethics of rendering a complete dispensing service by physicians; and that the delegates support a new interpretation which will clearly and definitely state that it is ethical for any physician to render a complete dispensing service in supplying glasses to his patients if he wishes to do so.

VICE-SPEAKER BAILEY: Reference Committee No. 3.

DR. T. D. ENGLEHORN (Monterey County):

RESOLUTION No. 4

WHEREAS, Advertising in medical society bulletins and other publications is not an ethical practice and is not permitted by or available to doctors of medicine; and

WHEREAS, Editors and business managers of some medical society bulletins and other medical publications do accept advertising from clinical laboratories owned and operated by persons who are not doctors of medicine and therefore not bound by the codes of ethics of any county medical society, the California Medical Association, or the American Medical Association; and

WHEREAS, Acceptance of such lay laboratory advertising by a journal lends to the advertising the connotation of approval or acceptance, despite blanket editorial allegation to the contrary; and

WHEREAS, The acceptance and publication of such advertising by lay laboratories creates an unfair advantage in favor of a nonmedical person and not available to the doctor of medicine within the various codes of ethics; now, therefore, be it

Resolved, (1) That this House of Delegates recommend to each county medical society that its bulletin not accept advertising from lay laboratories.

(2) That any notice or announcement by a lay laboratory that is printed in a county medical society publication be subject to the same restrictions that apply to similar announcements by doctors of medicine.

(3) That this House of Delegates instruct the C.M.A. delegates to the American Medical Association to introduce this same or a similar resolution in the next meeting of the House of Delegates of the A.M.A.; and

(4) That copies of this resolution be sent to all component medical societies of the C.M.A. and to the A.M.A.

VICE-SPEAKER BAILEY: Referred to Committee No. 3. Dr. Bullock.

DR. LEWIS T. BULLOCK (Los Angeles): We have been advised that each physician should come to the aid of community operations and assist in such organizations as the Heart Association. The adoption of this resolution will be of considerable aid to these public health organizations in promoting improvements in health.

RESOLUTION No. 5

WHEREAS, The public is led to believe that the income from the race tracks on certain days designated as "Charity Days" will be used for charitable and health promoting purposes; and

WHEREAS, A considerable portion of the net income on these days is actually diverted to other uses by means of the state tax; and

WHEREAS, Such division of funds to purposes different from those intended by the contributors amounts to a failure to fulfill the contract with the contributors; and

WHEREAS, The State would not allow a private agency to use funds contributed to a "charitable" organization for other purposes; therefore, be it

Resolved, That this House of Delegates state that all of the net income from "Charity Days" at the races should be used for charitable and health promoting purposes and the division of these funds by a state tax should be eliminated; and

That the legislative representatives of the California Medical Association be instructed to take all possible steps to bring this about.

VICE-SPEAKER BAILEY: That resolution goes to Reference Committee No. 3. Dr. Herbert C. Moffitt, Jr.

DR. HERBERT C. MOFFITT, JR. (San Francisco): This resolution reads as follows:

RESOLUTION No. 6

WHEREAS, "Service Type" plans have never successfully provided a full scope of medical care; and

WHEREAS, "Indemnity Type" plans provide a practical means of furnishing these medical services through the C.P.S. Indemnity Company; and

WHEREAS, Private insurance companies have developed a plan and are selling indemnification policies with combined dollar deductible and co-insurance features providing adequate and ideal coverage, without the necessity of fee schedules, which saves untold hours and dollars in administrative work; therefore, be it

Resolved, (1) That this House of Delegates direct the C.P.S. Trustees to set up a type of policy immediately, which would include dollar deductibility and co-insurance; and

(2) That C.P.S. be directed to push the sale of this type of insurance immediately, with even greater vigor than it sells the present service type policy; and

(3) That medical fees under C.P.S. indemnity would constitute the normal private fees of the in-

dividual physician, which would eliminate the necessity of a fee schedule.

VICE-SPEAKER BAILEY: That, Dr. Moffitt, will go to C.P.S. Committee.

DR. MOFFITT: The second resolution on behalf of the Medical Society has to do with the establishment of geographical areas and differentials between cost of medical care in different communities within the state. It reads:

RESOLUTION No. 7

WHEREAS, California is divided into many economic and geographic spheres by reason of diverse agricultural, manufacturing, urban and suburban communities; and

WHEREAS, There is a wide variation in the general income level among such communities; and

WHEREAS, The cost of providing the best medical care varies directly with such economic spheres; and

WHEREAS, It is unreasonable to assess low income areas with premiums equal to those of high income and urban communities; and

WHEREAS, It is not possible to provide the best medical care in urban areas from premiums designed for rural income areas; now, therefore, be it

Resolved, That C.P.S. be directed to develop these economic and geographical spheres and to develop premium schedules with accompanying fees which together will be commensurate with these great differences in subscribers' incomes and the cost of providing the best medical care.

VICE-SPEAKER BAILEY: Reference Committee on C.P.S.

DR. MOFFITT: The third resolution our society wishes to introduce is:

RESOLUTION No. 8

WHEREAS, The doctors of the San Francisco Medical Society have seen fit to endorse the C.P.S. $4,200 to $6,000 fee schedule; and

WHEREAS, The C.P.S. has indicated that the dual fee schedule will be supplied in bidding certain contracts; therefore, be it

Resolved, That the C.P.S. be obligated to pay the $4,200 to $6,000 fee schedule on any and all contracts in which the premium is collected on this basis, regardless of the quoting of a composite premium.

(The premium can be determined competitively with premiums quoted by other commercial bidders in respect to their present fee schedule.)

VICE-SPEAKER BAILEY: C.P.S. Reference Committee.

DR. MOFFITT: The next resolution describes the divergence of interest that develops between the field of Eye on one hand, and Ear, Nose and Throat on the other.

BY-LAWS AMENDMENT No. 5

WHEREAS, In the distant past the clinical and scientific material of ophthalmology and otolaryngology was closely associated and a common section served a useful purpose;

In recent years, however, the clinical and scientific material has been increasingly technical in nature in both divisions of the specialty. Administrative problems likewise have been confined to either the eye or the ear, nose and throat portions of the section, rarely to both; now, therefore, be it

Resolved, That the Eye and the Ear, Nose and Throat Sections of the California Medical Association be separated into two sections to be designated the Eye Section of the California Medical Association and the Ear, Nose and Throat Section of the California Medical Association. Each section to have its full complement of officers and to meet annually subject to the existing rules of the California Medical Association.

VICE-SPEAKER BAILEY: That goes to Committee No. 4, Amendments to the Constitution and By-Laws.

DR. MOFFITT: The next resolution has to do with opening our exhibit to the public.

RESOLUTION No. 9

WHEREAS, The public has repeatedly demonstrated its interest in the latest medical advances; and

WHEREAS, The medical profession desires that the public receive accurate information about medical progress; now, therefore, be it

Resolved, That the C.M.A. Council consider the possibility of opening the scientific and technical exhibits of the C.M.A. to the public on the last day of the annual meeting.

VICE-SPEAKER BAILEY: Reference Committee No. 3.

DR. MOFFITT: The next resolution was concerned with changes in the A.M.A. evaluation of advertising.

RESOLUTION No. 10

WHEREAS, The Board of Trustees of the American Medical Association in a recent action voted to discontinue the seal acceptance programs because of evidence from its scientific councils and committees that they can render a better service to the medical profession and the public by the substitution of evaluation programs for said seal acceptance programs; and

WHEREAS, There is at least a temporary lapse of critical evaluation of products which may be advertised in the state and county medical publications, it is imperative that a set of uniform standards be set up immediately by the *Journal of the American Medical Association*, state and county medical publication; now, therefore, be it

Resolved, That the American Medical Association be urged to maintain a critical evaluation of clinical evidence as to the use and efficacy of products advertised; that rules governing the acceptability of advertising copy be established and maintained, such rules to cover at least: (1) The elimination of unwarranted and/or extravagant claims; (2) A clear statement of the composition or the formula in all copy; (3) The pursuance of an ethical policy by all advertisers.

VICE-SPEAKER BAILEY: Reference Committee No. 3.

DR. MOFFITT: My last resolution:

RESOLUTION No. 11

WHEREAS, There has been an increasing shortage of teaching material in our medical schools; and

WHEREAS, For the future of medicine and in the public welfare it is important to have medical students trained thoroughly; now, therefore, be it

Resolved, That the C.M.A. Council review the sources of teaching material in all aspects, with the purpose of clarifying the eligibility requirements for patients in teaching institutions and establishing methods of augmenting the resources for teaching.

VICE-SPEAKER BAILEY: To Reference Committee No. 3.

Any further resolutions?

DR. R. W. HELMS (Los Angeles County): There are a number of men in our area who are dissatisfied with the present state of the Workmen's Compensation Law as it regards the free choice of physician; I am submitting this for them.

RESOLUTION No. 12

WHEREAS, Free choice of physician is one of the established ideals of the California Medical Association; and

WHEREAS, The present state workmen's compensation law conflicts with such free choice; now, therefore, be it

Resolved, That the California Medical Association study means of initiating legislative action to obtain greater medical freedom for the injured workmen.

VICE-SPEAKER BAILEY: To Reference Committee No. 3. Dr. Graeser.

DR. JAMES B. GRAESER (Alameda-Contra Costa County): This resolution is introduced to urge more emphasis on certain very important aspects of health insurance.

RESOLUTION No. 13

Resolved, That the California Medical Association Medical Services Commission and the Public Relations Department be instructed to undertake a long-term program of public education to demonstrate the economic advantages of deductibles and co-insurance in health insurance contracts.

VICE-SPEAKER BAILEY: That goes to Reference Committee No. 3.

DR. FREDERIC P. SHIDLER (San Mateo County):

RESOLUTION No. 14

WHEREAS, The physicians and surgeons of the Palo Alto, Los Altos, Mountain View municipalities of Santa Clara County have joined together for the purpose of establishing a full service, prepaid closed panel health plan available to groups employed either in Santa Clara or San Mateo County; and

WHEREAS, Such health plans force unwilling individuals to participate in them because of approval by a majority of employed individuals in a given business; and

WHEREAS, Such health plans force participant physicians to guarantee infinite service for finite compensation in advance of the need for any medical service; and

WHEREAS, The San Mateo County Medical Society has expressed its disapproval of the action of the physicians of the northern portion of Santa Clara County in proceeding with the formation of its own special prepaid closed panel health insurance plan; and

WHEREAS, Prepaid, full service, closed panel insurance schemes are disapproved by the California Medical Association as so-called "splinter" health plans; now, therefore, be it

Resolved, That the California Medical Association reaffirm its determination to act with the entire medical profession of the State of California to keep vital the California Physicians' Service as medicine's answer to prepaid panel health plans.

VICE-SPEAKER BAILEY: Referred to Reference Committee No. 3.

DR. E. W. HENDERSON (Alameda-Contra Costa County): No comment I believe necessary.

RESOLUTION No. 15

Resolved, That the California Medical Association concurs generally with the conclusions and recommendations of the Subcommittee on California's Coroner System, of the Assembly Interim Committee on Public Health, with particular reference to the following recommendations:

1. That qualifications should be established for the position of coroner in counties where it is not covered by an existing county merit system.

2. That serious consideration should be given to making the office of coroner appointive rather than elective, since public offices carrying administrative responsibility should be filled on a basis of qualifications and competence rather than popularity.

3. The coroner should not be connected with a mortuary. Coroners should be extremely cautious in delegating responsibility to private morticians.

VICE-SPEAKER BAILEY: Reference Committee No. 3. Dr. Sampson.

DR. J. PHILIP SAMPSON (Los Angeles County): I will just give a brief resume.

In Los Angeles we have been having to work within the policies of the medical school and the doctors of the district. Other places in the United States have had the same difficulty, and Dr. Culpepper from Mississippi has introduced the resolution to the American Medical Association requesting that they set up standards to give it entirely to free enterprise.

RESOLUTION No. 16

WHEREAS, Dr. J. P. Culpepper, Jr., for the Mississippi delegation, introduced the following resolution to the House of Delegates of the American Medical Association, which reads as follows:

"WHEREAS, It is imperative that a climate of free enterprise and ethical, private professional practice prevail toward the end of providing all Americans with the best possible medical care; and

"WHEREAS, Corporate, and tax-subsidized practice manifestly defeats these ends of service; and

"WHEREAS, There patently exists a barrier to these ends in the device of a tax-supported medical school that is engaged in the practice of medicine in which fees are levied and collected under a policy allowing this practice to employ physicians; now therefore be it

"*Resolved*, That the American Medical Association reaffirm its unalterable opposition to socialized and state subsidized medicine regardless of the form that it may assume; and be it further

"*Resolved*, That the House of Delegates of the American Medical Association is of the opinion that these principles should be considered by constituent and component medical societies together with all other facts pertinent to the local situation in all controversies arising in the employment of the medical faculty by state (tax) supported medical schools and be fully considered in effecting action within the framework of this policy."

Therefore, by this body, be it

Resolved, That the House of Delegates of the California Medical Association affirm Dr. Culpepper's resolution; and be it further

Resolved, That the delegates to the American Medical Association from the California Medical Association be instructed to aid and assist Dr. Culpepper's resolution.

VICE-SPEAKER BAILEY: Thank you, Dr. Sampson. That goes to Reference Committee No. 3.

DR. DAVE F. DOZIER (Sacramento): This came up before and is reintroduced for more mature consideration at this time.

RESOLUTION No. 17

WHEREAS, Nonspecified funds distributed by the American Medical Educational Fund are equally divided among medical schools regardless of their needs; and

WHEREAS, The sum of $100,000 to $150,000 represents a relatively small amount to each of the 78 medical schools in this country—the average school receiving not more than $2,000 or $3,000; and

WHEREAS, California's own, private, nonland-grant schools (that is, not state supported) are each in need of all monies available, and are indeed in serious jeopardy of their very existence; and

WHEREAS, Land-grant medical schools in this state have been in the past adequately sustained by our Legislature; therefore, be it

Resolved, That any fund contributed by the California Medical Association to the American Medical Educational Fund be earmarked as restricted to nonland-grant schools of medicine located in California.

VICE-SPEAKER BAILEY: Reference Committee No. 2.

DR. DOZIER: I have a second resolution, economic protection of C.M.A. presidents during incumbency.

RESOLUTION No. 18

WHEREAS, Service as president of California Medical Association entails tremendous personal, professional and economic sacrifices; and

WHEREAS, Income tax structures are such as to prevent the average doctor from accumulating any appreciable amount of operating capital; and

WHEREAS, These facts may well prevent fine dedicated doctors from accepting the supreme opportunity to serve the C.M.A., who otherwise are wholly competent for the office of president; therefore be it

Resolved, That the Council of the C.M.A. be requested to study the entire subject of some manner of protecting the president of the C.M.A. from undue professional and economic losses during his incumbency, and if feasible, report back to House of Delegates on some method of correcting this circumstance.

VICE-SPEAKER BAILEY: To Reference Committee No. 3.

DR. EDGAR F. MAUER (Los Angeles County): This is a brief resolution.

RESOLUTION No. 19

WHEREAS, The disposal of garbage and other refuse is a problem affecting the public health; and

WHEREAS, The proper disposal of such garbage and refuse at times constitutes a hazard to the public health; therefore be it

Resolved, That the private disposal of garbage or refuse shall be regulated with regard to the public health as conditioned by human occupancy of adjacent areas, and that the legislative representatives of the California Medical Association be instructed to utilize all means to prevent the use of public or private lands for the purpose of garbage or refuse disposal when such use shall be detrimental to the public health and welfare.

VICE-SPEAKER BAILEY: That goes to Committee No. 3.

DR. E. C. ROSENOW, JR. (Los Angeles County): I present this resolution in behalf of the Postgraduate Medical Education and the Pharmaceutical and

Drug Houses who enter postgraduate field on a competitive basis. We have no objection to the drug houses supporting medical education providing it is supervised at all times by recognized teaching institutions and medical organizations.

RESOLUTION No. 20

WHEREAS, Postgraduate medical education under the auspices of the legally constituted educational institutions of the United States is making progress of which the medical schools are justly proud; and

WHEREAS, There is a serious threat to its future development through the increasing inroads in postgraduate medical education on the part of the pharmaceutical houses and drug manufacturers; and

WHEREAS, These pharmaceutical houses and drug companies have engaged in the presentation of numerous postgraduate programs using various media including live programs and television, without having consulted recognized representatives of institutions of medical learning or the proper medical association, and in some instances have offered nationwide educational programs not only to practicing physicians, but by invitation, to medical students, interns, and residents; and

WHEREAS, Under the stimulation, an increasing number of pharmaceutical houses are entering the field on a competitive level; and

WHEREAS, The primary purpose of the pharmaceutical and drug houses is to sell drugs, and the primary purpose of medical schools is to sponsor medical education, and although ethical advertising is not to be condemned in any way, a clear distinction between advertising and education is essential; therefore, be it

Resolved, That this House of Delegates go on record as deploring these practices which may result ultimately in lowering standards and retarding progress in this most important phase of medical education; and be it further

Resolved, That the Council be instructed to take any action it deems necessary to restore the sole responsibility for postgraduate medical education to recognized agencies interested in medical education.

It is further recommended that the intent of this resolution be introduced by an appropriate resolution before the House of Delegates of the American Medical Association.

VICE-SPEAKER BAILEY: Reference Committee No. 3. Dr. Burwell.

DR. L. C. BURWELL (Los Angeles County): This resolution has to do with hospital accreditation. I have been asked to read all the whereases.

RESOLUTION No. 21

WHEREAS, The American Medical Association is the proper official organization representing medicine in the United States; and

WHEREAS, It is not only the privilege but also the obligation of this organization to protect and safeguard medical care to the patients and to assist in every way possible to maintain and further raise the present high standards of medicine and surgery; and

WHEREAS, The A.M.A. is the only organization which can and should speak officially for all physicians without regard to their particular field of practice; and

WHEREAS, There is a growing unrest due to the fact that the A.M.A. has not met its full obligations in regard to Accreditation of Hospitals for patient care; and

WHEREAS, There are two phases of Accreditation for Hospitals, one having to do with strictly housekeeping problems—the part which is unquestionably that of hospitals—and the other having to do with the care of the patient by the physician, staff organization and, of course, the intern and resident training program; and

WHEREAS, If there is not an early, acceptable discharge of this obligation, it will be increasingly difficult to execute this responsibility to the patient; to provide for him the best medical service in the most economical fashion. Now, therefore, be it

Resolved, That the American Medical Association be urged to assume its true responsibility by establishing a plan for Accreditation of Hospitals to be limited to the problems of patient and physician, and staff organization and the intern and resident training program; and be it further

Resolved, That if the American Hospital Association still has the desire to assist in the Accreditation of Hospitals that they be urged and invited to cooperate with the American Medical Association by limiting their accreditation activities to the strictly physical problems of hospital care which unquestionably is their responsibility; and be it further

Resolved, That at this meeting, May 1, 1955, of the California Medical Association, those who are delegates to the American Medical Association present this or similar resolution to the House of Delegates of the American Medical Association.

Mr. Chairman, in order that that may be acted upon at the forthcoming House of Delegates of the American Medical Association I'd like to have this treated as an emergency measure.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Burwell, it shall so be, but the rules being a little changed since last year, this will all be taken up by the reference committees at this meeting. That goes to Reference Committee No. 3. Any further resolution?

DR. SAM S. WOOLINGTON (Los Angeles County): Concerned with the possibility that this statement, "My child got polio; we could not afford to give it an injection," might come to haunt us at some future date, the doctors in Long Beach branch of Los Angeles County Medical Association developed

a polio-vaccine program providing for needy children. The details of that program are available to anyone who would like to check with us.

RESOLUTION No. 22

WHEREAS, There are many children in our California communities who will not be reached by the mass polio inoculation program of first and second graders, and whose parents cannot afford to pay for the injections of polio vaccine; and

WHEREAS, It is the traditional responsibility of the medical profession to see that medical care is available to all and that no one need be deprived because of inability to pay; and

WHEREAS, It is our responsibility to handle these matters as far as possible on a voluntary nongovernmental basis; therefore be it

Resolved, That the California Medical Association urge its member associations and local communities to set up polio vaccine programs to provide the injections when the vaccine is available on a voluntary nongovernmental basis for needy children whose financial eligibility for such care has been reliably established by proper screening procedures.

VICE-SPEAKER BAILEY: Referred to Reference Committee No. 3.

DR. OWEN F. THOMAS (Sonoma County): This resolution is in regard to Hoover Commission Recommendation.

RESOLUTION No. 23

WHEREAS, The California Medical Association should be concerned about the number of people given medical care by the Federal Government; and

WHEREAS, The California Medical Association should be concerned about the numbers of professional personnel whose time is occupied in giving this medical care; and

WHEREAS, The California Medical Association should be concerned about the cost of rendering this medical care; and

WHEREAS, The Hoover Commission has recommended changes in government organization which will tend to correct this undesirable situation; therefore, be it

Resolved, That the California Medical Association go on record as favoring the adoption of the recommendations of the Hoover Commission regarding federal medical care; and, therefore, be it further

Resolved, That the California Medical Association instruct its delegates to the American Medical Association to support similar resolutions in the House of Delegates of the American Medical Association.

VICE-SPEAKER BAILEY: Committee No. 3. Any further resolutions? New Business.

SPEAKER CHARNOCK: Twenty-nine resolutions have just been presented. This is the last opportunity you will have of presenting resolutions.

We have one or two announcements to make. The Committee on Committees will meet at 2:00 p.m. Monday, Room 5001.

Do not forget that all wives and doctors are invited to the Auxiliary Reception this afternoon between five and seven in the Rose Room, honoring Mrs. Arlo Morrison. Tickets for the President's dinner Monday evening are still on sale in Room No. 2.

Some of the delegates, some of the alternates who have been seated as delegates still do not understand that they vote as delegates when seated as such and their delegation chairman will so instruct them.

One-half hour after the recessing of this meeting the district delegates from District No. 11 will meet in Room 2045.

On Monday, at 9:30 a.m. in Room 2062, the delegates from Riverside, San Bernardino, Imperial and San Diego counties will meet. San Francisco delegates will have a caucus at 8:00 o'clock Wednesday morning in Room 2040.

Reference Committee No. 4 will meet in Room 2006 at 9:00 a.m. Monday morning, and C.P.S. Reference Committee will meet in Room 2127 Monday afternoon at 1:30.

The caucus of the Los Angeles delegation will meet formally at 2:00 p.m. on Monday afternoon in the Comstock Room on the second floor. That is the Fourth District, comprises Los Angeles County.

Reference Committee No. 3 has not yet been able to decide when it will meet. We know where, but not when; we will have that information for you as soon as it is available. Dr. Dozier.

DR. DOZIER: Reference Committee No. 1, which has to deal with reports of officers and committees, will meet in about fifteen minutes in Room 2005 to consider particularly Dr. Murray's report on Public Relations. The committee will meet otherwise regularly to consider unassigned business tomorrow morning starting at 9:30. Dr. Murray will not be able to be present tomorrow or Tuesday and so we beg your indulgence for this quickie meeting to consider this particular report.

SPEAKER CHARNOCK: That will be a meeting of Reference Committee No. 1. Dr. Weyrauch will tell us when Reference Committee No. 3 will start its deliberations.

DR. WEYRAUCH: Reference Committee No. 3 will meet in the English Room tomorrow morning at 9:00 a.m.

SPEAKER CHARNOCK: Reference Committee No. 3 will start its deliberations at 9:00 a.m. in the English Room.

I will request that the chairmen of the Reference Committees come to the desk to get their material. If there is no further business the House will recess. Reference Committee No. 2 has not told us yet when they will meet.

DR. HILL: Just a moment, please, Mr. Speaker. Reference Committee No. 2 will meet at 1 o'clock tomorrow afternoon in Room 2051.

SPEAKER CHARNOCK: One o'clock Monday, Room 2051.

We stand in recess until 9:30 Wednesday.

. . . The session was recessed at 4:30 p.m.

Wednesday Morning Session

The Wednesday morning session of the House of Delegates of the California Medical Association was held in the Ballroom of the Sheraton-Palace Hotel, San Francisco, California, Wednesday, May 4, 1955. The meeting was called to order by Vice-Speaker Bailey, of Los Angeles, California, at 9:30 a.m.

VICE-SPEAKER BAILEY: The House will be in order.

The first order of business is the Supplemental Report of the Credentials Committee, Dr. Francis Wisner, chairman. Will you make your report of it, Dr. Wisner?

DR. FRANCIS P. WISNER: Mr. Speaker, there is a quorum present. I move that we accept the visual roll call as evidence of the constitution of the House of Delegates.

VICE-SPEAKER BAILEY: Is there a second to that motion?

. . . The motion was seconded, put to a vote, and carried.

VICE-SPEAKER BAILEY: The roll call is completed. The next item of business is the Secretary's announcement of the Council's selection of place for the 1956 annual session.

EXECUTIVE SECRETARY JOHN HUNTON: The Council has selected Los Angeles, the first week of May 1956 for the annual convention.

ELECTION OF OFFICERS

VICE-SPEAKER BAILEY: Thank you. The next item is election of officers, the first being the President-Elect. Are there any nominations for President-Elect? Dr. Ewing L. Turner, of Los Angeles.

DR. EWING L. TURNER (Los Angeles): Mr. Speaker, the man whose name I am placing in nomination was born in 1893, came to California in 1902, and has lived here ever since. This man has not resided in any one area, but has resided all over California. At various times he has lived in Contra Costa County, San Bernardino County, Modoc County, Yolo County, Sacramento County, San Diego County, San Francisco County, and he hasn't been thrown out of Los Angeles County since 1929.

This gentleman served in the United States Army in 1917, he received his A.B. degree from the University of California in 1921, his M.D. degree from Harvard in 1925. He was for four years at the University of California Hospital in San Francisco.

In 1929 he came to Los Angeles County where in his spare time he practiced urology. He has served on the Los Angeles County Medical Association Council for six years, on the C.M.A. Council since 1947. He has been Vice-Speaker of this body for six years, he has been Speaker of this House for three years.

This man is past president of the Los Angeles Urological Society, the Hollywood Academy of Medicine, the Barlow Society for Medical History, and the Medical Symposium Society. Presently he is Associate Clinical Professor of Surgery at U.S.C., a member of the American Board of Urology, chairman of the Legislative Committee of the American Urological Association and alternate delegate to Dr. Vincent Askey to the American Medical Association.

This man is a man of proven ability, a tireless worker, a man of honor, integrity, and a man of character and high principles, a man who has worked long and hard and faithfully for all of us and for all of organized medicine, a man who is truly representative of all those great things that our great medical profession stands for in California. As chairman of the Los Angeles delegation it is my very high honor to place in nomination for the office of President-Elect of the California Medical Association my good friend and a friend of all California medicine, Dr. Donald A. Charnock, of Los Angeles.

VICE-SPEAKER BAILEY: Thank you, Dr. Turner.

DR. SAMUEL R. SHERMAN (San Francisco): Mr. Chairman, fellow delegates: During his wanderlust days Don Charnock chose to spend some time in San Francisco, where he received a major part of his secondary school education. While there he went to a school known as Mission High School, which for those of you who are not in San Francisco can be described as a high school in a tough part of San Francisco. There he fulfilled one of the principal prerequisites of that school: he learned to fight. If you couldn't fight in Mission High School you just didn't live to graduate.

He learned to fight so well that I feel this quality endears him to me as being a logical candidate for President-Elect of the California Medical Association. We need someone in that organization who will continually fight the doctor's problems, who will continue to fight their battles and will carry the doctor's story to the public. For this I think Don Charnock is eminently qualified and I take great pleasure to second his nomination.

VICE-SPEAKER BAILEY: Any further nominations? Dr. Dave Dozier, Sacramento.

DR. DAVE F. DOZIER (Sacramento): It is a great pleasure to second the nomination for President-Elect of C.M.A. of Dr. Don Charnock. I have known Don for more years than I think any other man here with the possible exception of Don Lum, and I can remember in 1921, when we were both in Boston, it was at Christmastime and cold; our room was cold, so we went to church. He has been a grand guy through the years; it is a pleasure to second the nomination of Don Charnock.

VICE-SPEAKER BAILEY: Dr. J. J. Crane, of Los Angeles.

DR. J. J. CRANE (Los Angeles): I'd like to ask Don publicly which county has the best fishing. I also would like to second Don's nomination.

VICE-SPEAKER BAILEY: Thank you, Dr. Crane. Are there any further nominations?

... A motion was made and seconded the nominations be closed.

VICE-SPEAKER BAILEY: A motion has been made and seconded the nominations be closed. All those in favor will say aye. The nominations are closed. Dr. Turner.

DR. EWING L. TURNER: I rise to a point of personal privilege, Mr. Speaker. We have several alternates who are not seated and we have a shortage of seats for the Los Angeles delegation's list. I wonder if we could beg your indulgence while we seat the alternates.

VICE-SPEAKER BAILEY: Yes, that is very important. I wonder if any of the Los Angeles delegation who are seated here who do not have ballots will hold up their hands.

Would you have Mr. Young bring the ballots in, please, for these alternates? He is passing them out.

VICE-SPEAKER BAILEY: Will you tell everyone who doesn't have ballots as Mr. Young passes them out so he will see how many. Now the question comes how you will vote for Dr. Charnock, by acclamation?

... A motion was made and seconded to vote for Dr. Charnock by acclamation. The motion was put to a vote, and carried....

DR. DONALD CHARNOCK: Ladies and gentlemen, in accepting your gracious selection I am conscious of the great honor accorded me. I accept this with deep humility and with the full realization of the challenge which this high office presents.

SPEAKER CHARNOCK: We have a lot of business to conduct today. The next order of business is the election of a Speaker of the House of Delegates. Dr. Fred Tyroler, here you are, Los Angeles County.

DR. FREDERIC N. TYROLER (Los Angeles County): Mr. Speaker, members of the House of Delegates: I wish to place in nomination the name of our present Vice-Speaker. I have known Dr. Bailey for the past 25 years since we attended college down the Peninsula. He was an outstanding man there and in following his career in the intervening years I have seen him reach the top in the practice of medicine. At the same time he has given tirelessly of his energy on behalf of medicine generally. Specifically, ten years in the Los Angeles Medical Association Council, one year as its president, and since then a member of the Board of Trustees. During his year as president he was instrumental in forwarding budgetary economies and streamlining of personnel and procedures that has resulted in the saving of some $100,000 annually to the Los Angeles C.M.A.

I think that is worth mentioning here, since the Speaker of this House becomes automatically a member of the Executive Committee of C.M.A. I think Dr. Bailey's special experience should be of invaluable aid to that committee. He served two four-year terms on the Board of Medical Examiners, seven years on the California Medical Council, fortunately holding both those jobs for several years so that he has been able to act as unofficial liaison officer between the Council and the Board of Medical Examiners.

For the past three years he has been Vice-Speaker of this House, during which time there has been no question of his ability, the firmness of his decisions, or his integrity.

All this experience makes him definitely the most logical candidate to succeed to the Speakership. Mr. Speaker, with the best interests of the California Medical Association at heart, I consider it a duty as well as a privilege to nominate Dr. Wilbur Bailey for Speaker of the House of Delegates.

SPEAKER CHARNOCK: Any further nominations? Dr. Cass.

DR. DONALD CASS: Mr. Speaker, members of the House: I propose the name of Dr. James Doyle for Speaker. The reason I propose his name is because Dr. Doyle is the overwhelming choice of the doctors in Los Angeles County.

Dr. Doyle has been very active in the workings of organized medicine, he is an Associate Professor of Gynecology, he has served two terms on the Council of the Los Angeles County Medical Association, he has been a member of our Legislative Committee, working in Sacramento with Dr. Kilroy and Dr. Murray the past few years. He has been very active in our Speakers' Bureau in Los Angeles, giving of his time freely. He has worked long and hard with the Public Health League, he is an experienced presiding officer and parliamentarian. Dr. Doyle was president and presiding officer of his county medical branch, he was president and presiding officer of the Beverly Hills Rotary Club, he was president and presiding officer of the Beverly Hills Chamber of Commerce.

I have known Dr. Doyle for many years. He has many friends, and I repeat again the Los Angeles caucus at the informal meeting chose Dr. Doyle two to one over his opponents, and in the formal caucus the yes vote was three to one for Dr. Doyle. It gives me a great deal of pleasure to nominate Dr. Jim Doyle to succeed Dr. Charnock.

SPEAKER CHARNOCK: Dr. Gibbons.

DR. HENRY L. GIBBONS, III (San Francisco): Wilbur Bailey was beginning his second four-year term on the State Board of Medical Examiners when my appointment began about four years ago; he is a past president of that body. In my opinion his experience on the Board of Medical Examiners, along with his many other official duties that you have just heard about has been of inestimable value to him and this experience, I think, will serve well in his role as Speaker. I therefore second with great pleasure the nomination of Wilbur Bailey for Speaker of the House.

SPEAKER CHARNOCK: Dr. Ewens, of Los Angeles County.

DR. FREDERIC EWENS (Los Angeles County): Thank you, Mr. Speaker. I wish to second the nomination of James Doyle. It is my earnest opinion that James Doyle does not suffer from lack of ability to handle the House of the C.M.A. It is my firm opinion that he has had ample experience in the diplomacy of handling problems. It is my experience that James Doyle has the ability to make the County of Los Angeles a very happy county. It is the opinion of the people in Los Angeles County that James Doyle is their choice, and I feel that as long as the County of Los Angeles has elected in their caucus James Doyle three to one it certainly must mean that they want James Doyle.

SPEAKER CHARNOCK: Dr. Blong, Los Angeles County.

DR. BLONG (Los Angeles County): It gives me pleasure to second the nomination of Jim Doyle. Before I do that I think in all fairness we want to look at the other side of the question. I think a man should be rewarded for good work done. If anything I say here would be construed as preventing that, I would not come up here, but I believe in the expanding economic structure of our state medical association we have plenty of opportunity to reward; we have many things opening up. I don't think any man will ever be deprived of the right to go up which is always his right and depends on his ability. My plea, in common words, is to open this thing up.

Some of you in the outlying counties know something of the work of the Public Health League. Years ago when we started the Public Health League we had to wait two years before we could inaugurate that movement. Why? The plea was there wasn't machinery set up for it. I asked the question then, "What machinery?" I ask it now. Since then I have seen younger men coming up in their societies, younger men eager and willing to go, and what has happened? They have been discouraged because they didn't have a chance to carry the ball. They will tell you that.

Reward a man for good work, yes; seize our opportunity to profit by that work, yes; carry the ball too long, no. What would you think of a football star if the coach should call him in after a season and pat him on the back and say, "Bill, you have done a wonderful job this year, we are going to let you carry the ball for the next two years." I practice what I preach. Out in our San Gabriel Valley branch they put me in unanimously as a delegate, and also on the Council. I didn't take it. There is no use putting me in an organization; let the other fellow come on up. We have sent Dr. Wadsworth up to the Council, a young man; we are sending up Ed Rosenow now, a young man, to the Council.

Now I received considerable ribbing from my friends in Los Angeles County about this young man business. What I mean by young man is not his birthday age, his span of life; what I mean is his opportunity to serve. I would like to digress and take that up a little. I have some samples of oratory in my pocket that I can hand out to any of the boys that think they are getting me down along that line. Dr. Doyle has been twice nominated. I have sat in at these caucuses a good many years. I haven't seen it but twice before, but here we have twice reaffirmed our ideas. I have sat in with Jim Doyle at Sacramento. I know something of his tact, I know something of his ability to make a decision. Dan Kilroy told you something of his ability at Sacramento. I hope you elect him. If he loses he will be a good loser and I think by that same token he should be a good winner.

SPEAKER CHARNOCK: Dr. Blong, thank you. Dr. Levy.

DR. CHARLES C. LEVY (Los Angeles): It is indeed an honor, privilege and pleasure for me to second the nomination of my old friend and fellow worker in legislative matters, Dr. Jim Doyle.

DR. SAM GENDEL (Orange County): It is with a sense of deep satisfaction that I should like to second the nomination of a man who has proved to this body his ability to carry on as Speaker of this House, Dr. Wilbur Bailey.

SPEAKER CHARNOCK: The names of Dr. Wilbur Bailey and Dr. James Doyle have been placed in nomination. Are there any further nominations? Hearing none, the chair declares the nominations closed. They are closed.

Does everybody entitled to vote have a ballot?

Drs. Crum of Alameda, Halley of Fresno, and Moffitt of San Francisco County, will act as tellers.

Will the chairman of the delegation see that all their seated delegates and alternates have ballots? We will now vote.

Dr. Crum, Dr. Halley and Dr. Moffitt, are you all here? Use No. 1 ballot. Drs. Crum, Halley and Moffitt, please come forward.

Will it make too much confusion if we proceed with the rest of the balloting? We have a full agenda today.

DR. TURNER: All the seated delegates in Los Angeles County haven't had their ballots given to them, and are now requesting ballots. Can't we hold up the vote?

SPEAKER CHARNOCK: You may.

MEMBER FROM THE FLOOR (Los Angeles County): Mr. Speaker, all the ballot pads are out as far as Los Angeles is concerned.

SPEAKER CHARNOCK: Los Angeles County is happy, you have got all your ballots. Has everybody got his ballot and finished with it? If everybody has his ballot I will announce once again the names of Dr. Wilbur Bailey and Dr. James Doyle have been placed in nomination. Has everybody turned in his ballot?

The next order of business is the election of a Vice-Speaker. Do I hear nominations? Dr. E. Vincent Askey, Alternate Delegate from Los Angeles.

DR. E. VINCENT ASKEY (Los Angeles): May I correct that? I am not an alternate sitting in this

House at all, I am a past president who has a voice and no vote so I did not vote and will not vote on any of the elections. However, I stand before you on a question of the caucus of the Los Angeles County Medical Association and I have been requested to again call to your attention certain things which have become established tradition in our association.

If you remember, I think three years ago, I rose before this same body to make a similar explanation and at that time I nominated Dr. Wilbur Bailey for Vice-Speaker. Before I make the nomination which I am going to make I want to call your attention to the fact, for some of the new delegates, of why certain people or certain groups have nominations to put before you.

Over a period of at least twenty years, to my knowledge, there has been an unwritten understanding and agreement, if I may call it a gentlemen's agreement, that Northern California shall have the chairman of the Council and the chairman of the Executive Committee and Southern California shall have the Speaker and the Vice-Speaker, so that if there seems to be in your mind a question of why Los Angeles is having all this turmoil and all, the reason is that you gentlemen have allowed Southern California to have the Speaker and the Vice-Speaker, with one or two irregular exceptions which always occur, and they were ironed out without any trouble or without any harsh feelings whatsoever.

Southern California wishes to continue with the gentlemen's agreement whereby we have the Speaker and the Vice-Speaker and Northern California the other appropriate, equal offices; therefore, at the request of the Los Angeles County caucus I have been asked to make this nomination for the Vice-Speakership.

There have been two caucuses, the first held at Los Angeles County Medical Association Building to which the southern counties were invited. At that time there was only one nominee made or given for the Vice-Speakership. Another caucus of the Los Angeles County Association only was held, at which time only one nominee was named.

It gives me great pleasure, therefore, to nominate the man who was the sole nominee of our caucuses. This man has been a past secretary-treasurer of the Los Angeles County Medical Association, he is a past president of the Los Angeles County Medical Association, a past member of our Board of Trustees of Los Angeles Medical Association and he has been a delegate to the American Medical Association and has given excellent and fine service. I am sure that he has the ability and the desire to work for the best interests of medicine. I think that he should be given your consideration, I believe he should be elected. It gives me great pleasure to nominate as Vice-Speaker of this organization Dr. Paul D. Foster, of Los Angeles.

SPEAKER CHARNOCK: Thank you very much, Doctor. The name of Dr. Paul Foster was put in nomination.

DR. WILLIAM E. COSTOLOW (Los Angeles): I wish to second the nomination of Dr. Paul Foster, for a number of years a member of the Los Angeles County Medical Association and a member of the Board of Trustees. I have had the opportunity to work with Dr. Foster during the past year as chairman of the Board of Trustees; I had the opportunity of appointing Dr. Foster to some of our important committees. He has always turned in an excellent performance, straightforward and efficient, as Dr. Askey has told you, in the various groups of organized medicine.

I might also add that he has had a great deal of experience as chairman of various civic and lay organizations. I feel that he is well qualified, he is a good fellow and well qualified to act as Vice-Speaker.

SPEAKER CHARNOCK: Thank you, Dr. Costolow. Dr. Ruddock first. Dr. Ruddock.

DR. JOHN C. RUDDOCK: Mr. Speaker and members of this House: For the past 36 years I have been a member of this House. I haven't missed any meetings, and during that time I have seen this organization grow and it amazes me to find that it is so large and there is so much business to be done it is a little unpleasant for me to second the nomination of a friend of mine to put him into such a job where there is so much work, but it is very pleasant that I can nominate a friend, or second a friend.

I'd like at this time to second the nomination of Dr. Paul D. Foster, for Vice-Speaker.

SPEAKER CHARNOCK: Dr. Mauer.

DR. EDGAR F. MAUER (Los Angeles): Mr. Chairman and members of the House of Delegates: It is my distinct pleasure to place the name of Dr. Robert J. Moes, of Los Angeles, in nomination for the office of Vice-Speaker. Dr. Moes has been a member of the Los Angeles County Medical Association for 25 years and during that time has served on most of the important committees. At this time he is chairman of the Library Committee, a very important post so far as the learning of our members is concerned.

During the war years he was chosen by Dr. Uhl as the City Health Officer, as to conditions in the civil defense program in that large area, and he attended this job very faithfully. He is a man of very high professional attainments, a member of the board of his hospital, California Lutheran Hospital, in Los Angeles, a member of the Council three terms, and served faithfully whenever given a committee.

He is presently a member of the Reference Committee No. 2 at this meeting of the California Medical Association and has been a staunch advocate of maintaining a balanced budget. I must say that his candidacy has flowered here in San Francisco as a spontaneous movement and I myself also say he is neither too young nor too old. I would like to place in nomination the name of Dr. Robert J. Moes.

SPEAKER CHARNOCK: Dr. Shaw next.

DR. GERALD W. SHAW: Mr. Speaker and fellow doctors: It gives me great pleasure to second the nomination of Paul Foster. I have seen his work in American medicine and he has done a very splendid job there and is very efficient in what he does.

DR. HERMAN ALLINGTON (Alameda): I have known Dr. Paul Foster for 25 years, since the days of our graduate training. I have followed his excellent work in organized medicine with admiration for a number of years. He has the unanimous support of his own caucus. I should like to bring him support from Northern California.

DR. FRED A. OLSEN (Humboldt County): I would, Mr. Speaker, second the nomination for Vice-Speaker of the House, Paul D. Foster, who has worked on many committees for the C.M.A. and for his own county. He has come up through the lines as chairman of his own county society and we as younger delegates in the north have found him very helpful, a tireless and experienced worker who has time to do a job well.

A MEMBER: I'd like to second the nomination of Dr. Moes for Vice-Speaker.

DR. DONALD CASS (Los Angeles): I have known Dr. Paul Foster for a little over 20 years. As has been stated, he is a tireless worker and I am sure his interest is in the private practice of medicine. I second the nomination of Dr. Paul Foster.

DR. J. E. YOUNG (Fresno): If you will bear with me, I'd like to read into the minutes of the California Medical Association, House of Delegates, proceedings of 1952, as reported to us in the official Journal, Volume 77, No. 1. I read from page 85, where what I have to say is something like having a baby; it is easy to conceive but very difficult to deliver. I read you this statement at this time. I quote:

"After talking it over with the people of the House of Delegates and the county it was decided in the best interest of California medicine that it would probably be a good idea if it were sort of unbroken, that the chairman of the Council and chairman of the Audit Committee, who was Executive Committee chairman, should be from the north. When it was found that if we had more votes in Southern California it might be well if we had better representation for the southern end of the state and a sort of gentlemen's agreement was that the Speaker of the House of Delegates and the Vice-Speaker should all be located in Southern California. That was differed with by one of our most respected and capable leaders of California medicine and it is a pleasure indeed to be the member of the House that conducts its business according to constitutional means, but by such procedures we hold our officers in respect but we cannot hold them all."

It is my opinion, therefore, that such procedure as has been suggested by a past Speaker of this House is contrary to the conditions of the California Medical Association. This so-called gentlemen's agreement in effect actually separates the remainder of the State of California from holding office in this body and those of us who are from other parts of the State of California other than Los Angeles or other metropolitan areas of this state reject that concept and we serve you notice here and now that so long as we are members of this House you shall contend with us for these offices.

It is certainly true that those of us who are members of this House are the sounding board of the officers of our organization and it is by their addresses to us that they are able to meet and speak to the people of California the voice of organized medicine, and it is because of that concept that we are therefore responsible for what they have to say and when we disagree with them it becomes our responsibility then to call them to task before some other comments are made.

It is also my opinion that so long as this organization abides by constitutional means as we have so readily written and listed in our own constitution, we will remain standing, and our prestige and strength in this state against our enemies will remain unimpaired. I urge you, therefore, to follow constitutional means in these processes, and because that issue has been injected into the election it gives me pleasure then to second the nomination of Dr. Moes, of Los Angeles.

SPEAKER CHARNOCK: The nomination of Dr. Moes has been seconded. Harry Garland, San Francisco.

DR. L. HENRY GARLAND (San Francisco): It has been my privilege to be a member of this association for almost 30 years, to be a delegate to this House for 25 of them. I realize the gravity of the decision you are about to make and it is my distinct privilege to second the nomination of Dr. Moes for Vice-Speaker.

SPEAKER CHARNOCK: The names of Dr. Paul Foster and Dr. Robert Moes have been placed in nomination. Are there any further nominations for the position of Vice-Speaker? It has been moved and seconded that the nominations be closed.

Those in favor will signify by saying aye; to the contrary? They are closed.

You will proceed to vote. Dr. Leslie B. Magoon, of Santa Clara, Dr. Bradley C. Brownson, Dr. J. W. Moore, of Ventura, will act as tellers, and will you come forward?

Dr. Magoon, Dr. Brownson, Dr. Moore; Ballot No. 2.

At this time the chair will announce that Dr. Doyle has been elected Speaker.

We will now vote on Ballot No. 2, if you please.

DISTRICT COUNCILORS

VICE-SPEAKER BAILEY: Gentlemen, in the interest of saving time may we have order and proceed to the District Councilors. First District, Francis E. West, San Diego, term expires. Will the chairman of the delegation from the First District make the report of the decision of San Diego County, comprising First District?

CHAIRMAN OF THE FIRST DISTRICT: We have an announcement to make to the House that in lawfully constituted assembly under Section 6, as chairman and secretary of the meeting, by written ballot Dr. Francis E. West was unanimously elected to succeed himself.

VICE-SPEAKER BAILEY: Under those sections, unless some comment from the House—I hear none—Dr. West is declared elected.

Next is the Fourth District, Dr. J. Philip Sampson, Santa Monica, term expires. Will the chairman of the Los Angeles delegation make a report? Is Dr. Turner around? Well, that report will be made later.

Next we come to Seventh District, Hartzell H. Kay, San Mateo, term expires.

CHAIRMAN OF SEVENTH DISTRICT: The Seventh District has met and elected James H. McPharlin, of Monterey County, as its District Councilor.

VICE-SPEAKER BAILEY: Thank you. Under the circumstances unless there be a challenge he is declared elected. He is elected.

The next is the Tenth District, Warren L. Bostick, Dr. Warren L. Bostick, Mill Valley, term expires. Will the chairman of that delegation make a report? Dr. Russell, Marin County.

DR. CARROLL A. RUSSELL (Marin County): As chairman of that delegation we duly met and have unanimously nominated Warren L. Bostick to succeed himself.

VICE-SPEAKER BAILEY: Thank you, Dr. Russell. Unless objection — hearing none — he is declared elected.

COUNCILORS-AT-LARGE

Here we have Councilors-at-Large for three-year terms.

First one, Dr. Benjamin Frees, Los Angeles, term expires, Councilor-at-Large. Any nominations for this position? Dr. Benjamin Frees.

DR. BENJAMIN FREES: Mr. Speaker, fellow delegates: It is a great privilege for me to stand here today and say that since 1946, after 40 years of membership in this organization, that I feel I should step aside for younger men and in doing so to have the privilege accorded me to choose my successor. By unanimous choice of the caucus of the Los Angeles County Medical Association I am going to give you the name of a man who graduated from Harvard, who came to Pasadena and has practiced there 15 years, who has been president of the Heart Association, who has been president of the Los Angeles Internists Association, who is Associate Professor of the U.S.C. Medical School, and who has been on various committees of this organization.

He is chairman of the Educational Program Committee of this body and he is editor of Audio-Digest. I give you a man of great stature. I place in nomination for Councilor-at-Large, Edward C. Rosenow, Jr., of Pasadena.

VICE-SPEAKER BAILEY: Are there further nominations to this position? No further nominations? Is there a motion to close the nominations? It has been moved and seconded to close the nominations. All those in favor will say aye. All those in favor of Dr. Rosenow will say aye. Dr. Rosenow is declared elected.

Again as Councilor-at-Large for three years, name of Hollis L. Carey, of Gridley, California, term expires. Dr. Sherman.

DR. SAMUEL R. SHERMAN: Mr. Chairman, fellow delegates: It gives me great pleasure to place in nomination for a second term as Councilor-at-Large a man to succeed himself, the name of Hollis L. Carey, of Gridley, California. Dr. Carey has served three years in this position and has served well. Besides that, all of you will remember that for the past year he has served brilliantly and ably as chairman of your great Medical Services Commission, so again I take great pleasure in presenting Dr. Hollis L. Carey, to succeed himself.

VICE-SPEAKER BAILEY: Any further nominations?

DR. A. E. BERMAN (Sacramento): Mr. Chairman, members of the House of Delegates: Representing the delegates from No. 10 Council District, it gives me great pleasure to second the nomination of Dr. Hollis Carey.

VICE-SPEAKER BAILEY: Are there further nominations?

... It was moved and seconded the nominations be closed.

VICE-SPEAKER BAILEY: It has been moved and seconded the nominations be closed. All those in favor of closing the nominations say aye. All in favor of Dr. Hollis Carey will say aye. Dr. Hollis Carey is declared elected.

DR. EWING L. TURNER (Los Angeles): I regret that I was out of the room when the call was announced for District No. 4 selection.

VICE-SPEAKER BAILEY: We welcome you back again. Will you explain what the District did?

DR. TURNER: The Los Angeles delegation selected for District Councilor of Fourth District Dr. E. E. Wadsworth, Jr.

VICE-SPEAKER BAILEY: Dr. E. E. Wadsworth, Jr., has been elected unless there is a challenge from the floor. Hearing none the chair declares him to be elected.

DELEGATES TO A.M.A.

Next we come to delegates of the American Medical Association. The first incumbent is Dr. Robertson Ward, of San Francisco, term expires.

DR. EMMETT L. RIXFORD (San Francisco): As vice-chairman of the San Francisco delegation it is my pleasure to be requested by that delegation to place in nomination as delegate to the American Medical Association the name of a close personal friend of mine. I place in nomination the name of Robertson Ward. Bob Ward has been known to

many of us and is widely known throughout the state. He has been a delegate to the A.M.A. for at least the last three terms. He has served us well there. Mr. Speaker, I nominate Robertson Ward.

VICE-SPEAKER BAILEY: Any further nominations for this position? Any further nominations? The chair declares the nominations closed, hearing no further nominations.

All those in favor of Dr. Ward will say aye. Opposed? Dr. Ward is declared elected.

The next office is that of Sam J. McClendon, San Diego, term expires. Any nominations?

DR. ARTHUR A. MARLOW (San Diego County): Mr. Speaker, fellow delegates: Words would be superfluous. I propose the name of Dr. Sam J. McClendon to succeed himself as delegate to the American Medical Association.

VICE-SPEAKER BAILEY: Thank you, Dr. Marlow. Are there any further nominations? Hearing none the chair declares the nominations closed.

Those in favor of Dr. McClendon will say aye. Dr. McClendon is declared elected.

Next, Dr. Eugene F. Hoffman, of Los Angeles, term expires.

DR. JOHN C. RUDDOCK (Los Angeles): Mr. Speaker and members: Again I arise. It gives me a great deal of pleasure to nominate Dr. Eugene Hoffman to succeed himself as delegate to the American Medical Association.

VICE-SPEAKER BAILEY: Eugene Hoffman has been nominated. Dr. Boyer, from Los Angeles.

DR. KENNETH H. BOYER (Los Angeles): It gives me great pleasure to second Dr. Hoffman's nomination.

VICE-SPEAKER BAILEY: Thank you, Dr. Boyer. Any further nominations? Hearing none the chair will declare the nominations closed. Dr. Hoffman is declared elected.

Dr. John W. Green, of Vallejo, term expiring.

DR. L. H. FRASER (Alameda County): I wish to nominate for A.M.A. Delegate the man who served us so well, not only as our president, but also as your president two years ago, John W. Green.

VICE-SPEAKER BAILEY: Dr. John W. Green has been nominated.

DR. BOSTICK (Marin County): It gives me great pleasure to second the nomination of Dr. Green as delegate.

VICE-SPEAKER BAILEY: The chair, hearing no objection, declares the nominations closed. Dr. Green is nominated.

All those in favor of Dr. John W. Green signify by the usual sign. Opposed? Dr. Green is elected.

Next is Lewis A. Alesen, of Los Angeles, term expires. Dr. Crane.

DR. J. J. CRANE (Los Angeles): Mr. President, members: I wish to place in nomination the name of Lewis A. Alesen to succeed himself. I wish this to be a rising unanimous vote.

VICE-SPEAKER BAILEY: Any objections? Even though the chair might not be in favor, it has to ask for further nominations. Any further nominations? Hearing none, the chair declares the nominations closed. We know Dr. Alesen is ill, he couldn't be here. All those in favor will respond by rising.

... Rising vote. (Applause.)

VICE-SPEAKER BAILEY: Will Dr. Crane convey our appreciation to Dr. Alesen?

Dr. Frank A. MacDonald, Sacramento, next, term expires.

DR. DOZIER: I'd like to place in nomination the name of Frank A. MacDonald to succeed himself.

VICE-SPEAKER BAILEY: Any further nominations to this position? Dr. Desimone.

DR. LEON O. DESIMONE (Los Angeles): It gives me great pleasure as a southerner to support a northerner. I second the nomination of Frank MacDonald.

VICE-SPEAKER BAILEY: Any further nominations? The chair hearing none, declares the nominations closed.

Those in favor of Dr. MacDonald say aye. Opposed? Dr. Frank MacDonald is declared elected.

Dr. Paul D. Foster, Los Angeles, term expiring. Dr. Donald Cass.

DR. DONALD CASS (Los Angeles): I wish to nominate Paul Foster to succeed himself. He is the choice of the Los Angeles group and I will say that he is a very fine delegate.

VICE-SPEAKER BAILEY: Any further nominations?

DR. JOSEPH M. DE LOS REYES (Los Angeles): I'd like to second the nomination of Paul D. Foster, Mr. Chairman.

VICE-SPEAKER BAILEY: Any further nominations? Hearing none, the chair declares the nominations closed.

Those in favor of Dr. Foster respond by saying aye. Dr. Foster is declared elected.

At this time the chair will announce that Dr. Paul Foster has been elected as Vice-Speaker. ... Applause.

VICE-SPEAKER BAILEY: The next offices are those of Alternates to the American Medical Association. The first one is Henry Gibbons, III, of San Francisco, alternate to Dr. Robertson Ward.

DR. ROBERTSON WARD: Mr. Speaker, it gives me great pleasure to nominate Henry Gibbons to succeed himself as alternate delegate to the American Medical Association. We have got him in training now and hope before long he can step up to the position of delegate.

VICE-SPEAKER BAILEY: The name of Dr. Henry Gibbons has been put in nomination. Are there any further nominations? The chair, hearing none, declares the nominations closed.

Those in favor of Dr. Henry Gibbons as alternate will signify by saying aye. Dr. Henry Gibbons is elected.

The next office is that of Dr. A. E. Moore, San Diego, incumbent, alternate to Dr. Sam J. McClendon. Are there any nominations for this position?

DR. RALPH M. KING (San Diego County): I'd like to nominate Dr. A. E. Moore to succeed himself as alternate to the A.M.A.

VICE-SPEAKER BAILEY: The name of Dr. Moore has been placed in nomination to succeed himself. Are there any further nominations? The chair, hearing none, declares the nominations closed.

Those in favor of Dr. Moore will signify by saying aye. Contrary minded? Dr. Moore is elected.

The next office, No. 3, Frederic S. Ewens, Manhattan Beach, alternate to Eugene Hoffman. Dr. Hoffman.

DR. EUGENE HOFFMAN: Mr. Speaker, members of the House: I wish to place in nomination, to succeed himself as alternate to the American Medical Association, Frederic Ewens. He has been a tireless worker and we need him back. Thank you.

VICE-SPEAKER BAILEY: The name of Frederic S. Ewens has been placed in nomination. Dr. Foster.

DR. PAUL D. FOSTER: I'd like to second the nomination of Dr. Fred Ewens to succeed himself as alternate.

VICE-SPEAKER BAILEY: Dr. Kilroy.

DR. DAN KILROY: Mr. Speaker, on behalf of the Sacramento delegation the north wants to repay the compliment of the south by seconding the nomination of Fred Ewens.

VICE-SPEAKER BAILEY: The name of Dr. Fred Ewens has been placed in nomination. Any further nominations? The chair, hearing none, declares the nominations closed.

All in favor of Dr. Frederic S. Ewens will signify by saying aye. Dr. Ewens is declared elected.

The next office, Dr. Orris R. Meyers, Apple Valley, alternate to Dr. Green.

DR. FRED A. OLSON (Humboldt County): Mr. Speaker, I wish to place in nomination the name of Warren Bostick as alternate to A.M.A. for Dr. John Green as delegate, and to succeed Dr. Orris R. Meyers of Apple Valley.

At this time I wish to yield the floor to Dr. Carl Hadley of San Bernardino.

DR. CARL M. HADLEY (San Bernardino): I would like to discuss the situation of Dr. Meyers who has emigrated to San Bernardino County and is now living in Apple Valley. We wish the House to be informed on this. San Bernardino County desires that District No. 10 present a man from their own area. This is a geographic situation which our district wishes to respect. We ask for the consideration of Warren Bostick as alternate to Dr. Green, to succeed Dr. Orris R. Meyers. I should like to second his nomination. Dr. Bostick is from Mill Valley. He is 41. For three years he has been the Councilor for the Tenth District. He is a young and aggressive individual. All of us have one word to express our admiration when we see him work and that is the word "accomplishment."

VICE-SPEAKER BAILEY: The name of Dr. Warren Bostick has been placed in nomination.

DR. ELLIS (Kern County): As a very close friend of Dr. Bostick I wish to second the nomination.

VICE-SPEAKER BAILEY: If there are no further nominations the name of Warren Bostick has been placed in nomination. Any further nominations? The chair, hearing none, declares the nominations closed.

Those in favor of Dr. Warren A. Bostick will respond by saying aye. Dr. Bostick is elected.

Next office, Dr. J. B. Price, of Santa Ana, alternate to Dr. Lewis Alesen.

DR. L. E. WILSON (Orange County): For the third time it gives me pleasure to nominate Dr. J. B. Price to succeed himself as alternate delegate to the American Medical Association.

VICE-SPEAKER BAILEY: Dr. Wilson, of Orange County, has placed the name of Dr. J. B. Price in nomination. Are there any further nominations? The chair, hearing none, declares the nominations closed.

Those in favor of Dr. J. B. Price will signify by saying aye. Dr. Price is elected.

The position of alternate to Dr. MacDonald, Dr. Henry A. Randel, Fresno County incumbent.

DR. J. E. YOUNG: I wish to place in nomination to succeed himself, Dr. Henry Randel of Fresno.

VICE-SPEAKER BAILEY: Dr. Young has placed in nomination Dr. Henry Randel of Fresno, as alternate to Dr. MacDonald.

DR. MACDONALD (Sacramento): I'd like to second the nomination of Henry Randel for alternate. Henry has done a swell job in the conventions we have had previously and I am sure will continue to do so.

VICE-SPEAKER BAILEY: Dr. Desimone.

DR. LEON O. DESIMONE (Los Angeles): The south is again proud to lend its support to the mid-portion of the state. I second the nomination of Dr. Henry Randel.

VICE-SPEAKER BAILEY: Dr. Henry Randel's nomination has been seconded by the south. Any further nominations? Hearing none the chair declares the nominations closed. Dr. Randel is elected.

The next position is alternate to Dr. Paul D. Foster, Arthur A. Kirchner, the incumbent.

DR. CHARLES C. LEVY (Los Angeles): I would like to place in nomination the name of Dr. Arthur A. Kirchner to succeed himself as alternate to the American Medical Association. Dr. Kirchner showed the first time he was an alternate he was capable of keeping the reference committee of the A.M.A. in line. I think you will recognize his activities here this last summer.

VICE-SPEAKER BAILEY: The name of Dr. Kirchner has been placed in nomination. Any further nominations? The chair, hearing none, declares the nominations closed.

Those in favor of Dr. Kirchner as alternate signify by saying aye. Dr. Kirchner is elected.

The next position is that of alternate to Dr. Dwight L. Wilbur, held by the late Dr. J. Frank Doughty. Dr. Wilbur.

DR. DWIGHT L. WILBUR (San Francisco): Mr. Speaker, members of the House: I think all of us regret the passing of Frank Doughty. He did not only a great job for C.M.A. and California Physicians' Service, but also as delegate to the A.M.A.

In casting around for some young man in the California Medical Association to succeed Dr. Doughty and eventually hold the office of delegate to A.M.A. the name has occurred to a number of us of one of the rising young men in this area of California. Dr. Moffitt is an internist, practicing in San Francisco now for some years. Since the war he has added considerable dignity to the illustrious name which he carries. He has been a member of the House of Delegates for several years, he has been a member of important committees in the San Francisco Medical Society and is currently its president. It gives me a great deal of pleasure to nominate Dr. Moffitt as alternate delegate to the A.M.A.

PRESIDENT-ELECT SIDNEY J. SHIPMAN (San Francisco): Mr. Speaker, and members of the House: Last year I was riding back from the east with Dr. Cline, and we were talking about the matter of alternate delegates to the A.M.A. and John told me he thought it was one of the most important posts that we could select. He said that the influence of the California Medical Association would be felt in years to come by the caliber of the young men we chose as alternates and if this House has been careless in the past it should rectify that in the future, because I, and I am sure you, would like to be represented by the finest type of men we have in California in the A.M.A.

When I came to San Francisco one of the men who was kindest to me was Herbert Moffitt's father. It has been my pleasure to watch Herbert Moffitt, Jr., follow in the footsteps of his father and there is nobody I would rather have represent me in the A.M.A. than Herbert Moffitt, Jr. I therefore take great pleasure in seconding his nomination.

DR. LEON FOX: Mr. Speaker, members of the House of Delegates: I'd like to place in nomination the name of a man who has certainly worked hard in the service of California Medical Association. He has been one of my buddies since 1931, has been a delegate since 1933 and he is not too old, certainly, to do good work. He has done good work on the Industrial Fee Schedule Committee. He is certainly an ardent worker, and that is J. G. Josephson.

VICE-SPEAKER BAILEY: The name of J. G. Josephson has been placed in nomination.

DR. W. L. ARGO (Fresno County): I would like to propose the name of a man who also comes from a small community in the Sixth District, as Dr. Doughty did, the name of Dr. James W. Feldmayer of Exeter. Those who know Dr. Feldmayer could talk at great length of his accomplishments. It isn't my purpose to declaim at length but Dr. Feldmayer brings three important qualifications as a candidate. First, he represents that finest section of American medicine, the competent, vigorous, small town practitioner.

The second qualification which he can bring you is that of experience. He has been a delegate to the House for five years, he has been a member of reference committees for two years, he has worked tirelessly and well.

The third qualification I think very important; he has both the time and the willingness to give to this vital position. It is a pleasure to place the name of Dr. Jim Feldmayer, of Exeter, in nomination.

A MEMBER: It gives me great pleasure, coming from the county from which Dr. Doughty has come, to second the nomination of Dr. Feldmayer and to add a word from our county on the needs of that small community represented at the A.M.A. level as well as a larger community such as San Diego, Los Angeles, San Francisco.

Dr. Feldmayer has had experience at the local level and in his county medical society, and has served on the boards of hospitals in smaller communities. I think he can replace a little bit the loss at the A.M.A. level of the country physicians that is felt by the loss of Dr. Doughty.

DR. HARTZELL RAY (San Mateo County): It is a pleasure for me to second the nomination of Dr. Joe Josephson.

DR. EDWARD C. HALLEY: It gives me great pleasure to second the nomination of Dr. James E. Feldmayer, of Exeter.

VICE-SPEAKER BAILEY: The names of Herbert Moffitt, Jr., Joseph G. Josephson and James Edward Feldmayer have been placed in nomination.

MEMBER FROM THE FLOOR: I suggest we do not know these men; I wonder if they'd stand. Is that in order?

VICE-SPEAKER BAILEY: That is perfectly in order, sir. Will Dr. Herbert C. Moffitt, Jr., stand up? Dr. Joe Josephson, please stand up, and Dr. James Edward Feldmayer. . . . Applause.

Are there any further nominations for this position? The chair, hearing none, declares the nominations closed. You will ballot on Ballot No. 3. The chair will appoint Roderick A. Ogden of Kern County, Dr. Tenero D. Caruso of Los Angeles County, and Dr. David L. Reeves of Santa Barbara County, as tellers. Will you please come forward? This will be Ballot No. 3. The names are Dr. Herbert C. Moffitt, Jr., Dr. J. G. Josephson, Dr. James Edward Feldmayer.

SPEAKER CHARNOCK: While we are passing the ballots and collecting them we will have the report from Dr. Lum, chairman of the Council, of the nominations for C.P.S. Board of Trustees.

DR. DONALD D. LUM: Mr. Speaker, reporting for the Council, I wish to place in nomination Dr. Dave Dozier to succeed Frank A. MacDonald, Dr. Arlo A.

Morrison to succeed himself, Mr. Tom Hadfield to succeed himself; Rt. Rev. Msgr. Thomas J. O'Dwyer to succeed himself. May I say Mr. Carey S. Hill would have been renominated. Unfortunately his untimely decease prevented that. His passing is a great loss to C.P.S.

May I say that there is a vacancy of a lay person that has not been filled at the present moment.

VICE-SPEAKER BAILEY: The names of Dr. Dave Dozier, Arlo A. Morrison, Mr. Thomas Hadfield, and the Rt. Rev. Msgr. Thomas J. O'Dwyer have been placed in nomination. Nominations from the floor are in order and they have to be nominations for the specific office for which these four gentlemen have been nominated. Are there any nominations from the floor for C.P.S. Trustees?

... It was moved and seconded the nominations be closed.

VICE-SPEAKER BAILEY: It has been moved and seconded that the nominations be closed. Those in favor signify by saying aye. Dr. Dave Dozier, Arlo A. Morrison, Mr. Thomas Hadfield, Rt. Rev. Msgr. Thomas O'Dwyer, those in favor of those four gentlemen will signify by saying aye. They are elected.

Is the Secretary ready to announce the Council's nominations of Standing Committees?

DR. SIDNEY J. SHIPMAN: Mr. Speaker, the Secretary is not here, may I do it for him? You have before you the outline which is largely the work of the president, Dr. Morrison, in reorganizing the committee structure of the C.M.A. As you see, an attempt has been made to streamline the authority and to interpret the various committees and commissions in an effective manner.

(Dr. Shipman read the list of Council appointments for the various commissions and committees.)

Those are the committees as set up. Mr. Speaker, I move to accept that report.

... The motion was seconded.

SPEAKER CHARNOCK: The report on the committees has been presented to you. Is there any discussion? Those who are in favor of this group of committees will signify by saying aye. Contrary minded? These committees are as reported.

DR. LUM: I omitted the Cancer Commission, the membership of which is exactly as it was last year.

SPEAKER CHARNOCK: We will accept the Cancer Commission as of last year if there is no objection.

There is no Unfinished Business.

The chair would like to suggest that as soon as we get this balloting finished that this House recess until one o'clock. If we get in to lunch just a trifle ahead of all these businessmen around town we will get fed a lot sooner. Is there anybody who disapproves of that?

We will wait then for this ballot and then the first order of business this afternoon will be the Reference Committees and they will all be ready to report. Will you please be in order?

For the position of alternate for Dwight L. Wilbur, Dr. Feldmayer is declared elected.

Dr. Bailey has an announcement.

VICE-SPEAKER BAILEY: Mr. Speaker, I rise to a point of personal privilege. We as doctors are all accustomed to learning from our more experienced colleagues. We have to depend for advice in this House of Delegates on the Speaker and Vice-Speaker, and it seems to me it would be in the best interest of the Association to ask Dr. Doyle to sit at the feet of the master, Dr. Charnock. I would deem it a privilege if the Speaker would allow him to take my place in the proceedings this afternoon so he will have an opportunity to watch Dr. Charnock at work. I would ask Dr. Cass to bring Dr. Doyle up here so that I may congratulate him and commiserate at the same time.

DR. ASKEY: Mr. Speaker and members of the House of Delegates: I think that Wilbur Bailey has had the interests of medicine at heart; he is one of our good men. He has served us well as he sits in the chair as Vice-Speaker. I think he should have the honor and privilege of representing us until the exact end of his service. I object to Jim Doyle's taking his seat at this time. I would like to amend Dr. Bailey's motion to state that Dr. Jim Doyle be allowed to sit beside the Vice-Speaker and learn from him.

SPEAKER CHARNOCK: We will have Dr. Doyle sit at Dr. Bailey's side.

I have several announcements to make. The San Francisco delegates will meet in Room 2127 during the noon recess.

The Council will meet at noon. Mr. John Hunton will arrange the room, and new members of the Council are expected to be present. We will meet in the California Room.

I have a very pleasant announcement to make. Dr. Bob Hanford, of Fresno, who has just returned from service in Europe and is a young general practitioner in Fresno and the eastern area, won the physician's automobile. I think that is a wonderful thing. It couldn't happen to a nicer man.

... We stand in recess until one o'clock.

Wednesday Afternoon Session

The Wednesday afternoon session of the House of Delegates of the California Medical Association was held in the Ballroom of the Sheraton-Palace Hotel, San Francisco, California, Wednesday, May 4, 1955. The meeting was called to order by Speaker Charnock, of Los Angeles, at 1:15 o'clock p.m.

SPEAKER CHARNOCK: Will the House please be in order. As the first order of business, will Wilbur Bailey please bring Dr. James Doyle and Dr. Paul Foster to the rostrum.

REPORT OF REFERENCE COMMITTEE No. 1

The first order of business is the report of Reference Committee No. 1, Dr. Dave H. Dozier, of Sacramento. Dr. Dozier.

DR. DAVE H. DOZIER (Sacramento): Mr. Speaker, members of the House of Delegates: Reference Com-

mittee No. 1 has reviewed the reports of the officers, the Council and the committees and commissions that have been referred to it.

As is customary, our report is herewith submitted in sections for your consideration. There are no mimeographed copies of this report, gentlemen.

Section 1. Reports of the President and the Council, members of the Council and Administrative Bodies. The committee feels these reports reflect a great deal of hard work and fine service to our association and that these officers are to be commended for their devotion and their competence.

Mr. Speaker, I move you the adoption of this section of the report.

... The motion was seconded.

SPEAKER CHARNOCK: The adoption of this section of the report has been moved and seconded. Is there any discussion?

... The motion was put to a vote, and carried.

DR. DOZIER: Section 2, Special Aspects of the Council's Report. A varied number of activities has been presented in the Council's report which we feel deserve special comment.

(a) We wish to call attention to the Conference on Physicians and Schools. This is apparently a most worthwhile step in the right direction public health-wise, and in the sense of community service.

(b) Cooperation and liaison between the Council and State Department of Public Health appears to be a most favorable cooperative function redounding to the mutual benefit of the public and the California Medical Association.

(c) Activities with and in behalf of the Student American Medical Association culminated in recent various successful conferences which appear to merit a most worthwhile commendation in support of the Council's efforts in assisting these men and women.

(d) The committee is aware of the studies being conducted by Rollen Waterson Associates. The committee feels this is a very valuable and important project that promises to provide more aid and material to the members of the California Medical Association. The committee further feels that as this work progresses suitable reports should be made available to the county medical associations and members of the California Medical Association.

Mr. Speaker, I move you the adoption of this section of the report.

... The motion was seconded.

SPEAKER CHARNOCK: It has been moved and seconded this section of the report be adopted. Is there any discussion?

... The motion was put to a vote, and carried.

DR. DOZIER: Section 3, Reports of Committees and Commissions. Your reference committee has studied the reports of the various committees and is greatly impressed with the breadth and scope of the association's activities and the fine services rendered by committee members. These reports, however, do point up in several instances the need of a realigning the committees in defense of their interests. Again the committee wishes to commend the report of the Committee on Postgraduate Education; its fine efforts have not only been sustained but have become even more successful.

The Report of the Medical Services Commission indicates that its efforts continue to grow and be of increasing service to the public and profession along the programs outlined by the medical section; it shows it is a group concerned with the public welfare and fee schedules and various programs of medical care of California citizens.

The Committee on Rural Health we feel is to be commended for its very excellent work.

Mr. Speaker, I move the adoption of this section of the report.

... The motion was seconded.

SPEAKER CHARNOCK: It has been moved and seconded to accept this section of the report. Is there any discussion?

... The motion was put to a vote, and carried.

DR. DOZIER: Section 4, Committee on Public Relations. Your reference committee has saved for a special section its report on Public Relations. Over 90 per cent of the time spent by your committee was the consideration of Dr. Murray's report and the various phases of public relations. The breadth of the discussion and intensity and keen assertion of the views expressed by many of the discussants was eloquently presented. Specifically your committee made several recommendations. A careful study of these recommendations, as presented, seem to your reference committee to well encompass both the ideas of the Public Relations Committee and the majority of those that engaged in the discussion of the entire subject.

To this committee it was apparent our one great concern was the continuance of the active, aggressive, effective Public Relations Committee program. We feel that this point cannot be too strongly emphasized.

Your reference committee is aware that the Council's recommendations for revision of the committee has been concerned with No. 4. We would be derelict in our duty if we do not recommend that the Public Relations Committee be given full status and advised of the many subjects coming under the head of public relations. We feel the introduction of new topics for Audio-Digest, adequate expansion and knowledge of important factors and findings of medical care, the practice of medicine and medical economics, student A.M.A. activities, distribution of the type of pertinent matters of this type should come into this committee; we feel this committee should cooperate with the Council.

No. 1. We feel continued emphasis on development of an effective public health program is of the greatest importance in the months ahead.

I move you the adoption of this section of the report.

... The motion was seconded.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. DOZIER: In conclusion, Mr. Speaker, I wish to thank especially the other members of the committee for their assistance, Dr. Thomas D. Dozier, and particularly Roger A. Vargas, San Bernardino, in preparing this report, truly a report of the entire committee. I would like to thank Mrs. Barbara Corley for her patience in reading our notes and typing this report.

I move the adoption of the report as a whole.

... The motion was seconded.

SPEAKER CHARNOCK: The adoption of the report as a whole has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

SPEAKER CHARNOCK: The chair wishes at this time to reiterate the thanks to the three members of the Reference Committee.

The next order of business is the Report of Reference Committee No. 2, Thomas P. Hill, Lakeport, chairman. Dr. Hill.

DR. THOMAS P. HILL (Lakeport): Mr. Speaker, members of the House of Delegates: Your Reference Committee No. 2, composed of Thomas P. Hill, Lakeport, Henry Gibbons III, San Francisco, and Robert J. Moes, of Los Angeles, has been presented with and approved the reports of the secretary-treasurer and executive secretary. The already heavy schedule of Dr. Albert C. Daniels in attending meetings of the Council, the Executive Committee, Committee on Postgraduate Activities and Cancer Commission has now one added organization, presiding over the Conference of Physicians and Schools, and in so doing all of these have been handled very satisfactorily.

Mr. John Hunton, executive secretary, has continued to perform his duties in the very efficient manner he has done in the past, which is essential to the success of this organization.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. HILL: The budget proposed by the Council was carefully studied and discussed and the committee wishes to express its thanks to the many delegates who appeared before it and participated in the discussion. We noted that there was a deficit of $45,118 which was partially offset by a profit of $14,550 from CALIFORNIA MEDICINE, thus giving a net deficit of $30,568. This would make the second year in which we had spent more money than we had received.

Last year was exceptional in that we set aside a large amount for Rollen Waterson Associates to do some very necessary work and we donated $100,000 of surplus to the American Medical Education Foundation, with the resulting deficit of $115,205. However, as Dr. William Bender pointed out, as all of us decry the deficit spending and an annual unbalanced budget in political economy, your committee believes that should not be a continuing condition in our own organization. Therefore, in an effort to limit our estimated expenditures, or estimated income without damage to vital functions of the organization, your committee recommends some changes in the figures proposed by the Council.

Of the eight changes made, four were decreased below the amount spent last year, two were decreased below the amount budgeted last year, one was increased, and there was an increase in amount budgeted for a new committee, that on Malpractice Insurance.

You have your budgets in front of you. Take up Item 17-d, A.M.A. Delegates—$22,000 is requested, $20,000 was recommended. Last year this item was budgeted for $21,000 and $24,500 was the estimated expenditure. We feel perhaps a little more economy can be exercised by our representatives.

Item 21, Cancer Commission—$26,000 was the estimated expenditure last year and no one appeared before us to explain the need for increasing the fund to $30,638, nor how the $30,638 was to be spent. When you think of that, $29,000 should be sufficient, the same as now.

No. 3, Postgraduate Programs—$33,900 was requested, an increase of $5,900, apparently for an assistant at $6,000 a year, the same salary as Dr. Broaddus receives. Dr. Broaddus has put in a great deal of time and effort on this program and we can't feel the justification of having the assistant having the same salary to understudy; however, because of the great value of this program to outlying counties we feel the program should be encouraged and feel an increase of $2,000 should be allowed to be used as the association feels best, whether an increase to Dr. Broaddus' salary or otherwise.

No. 24, Medical Services Commission—$500 increase, from $30,000 to $30,500 was requested. Under the reorganization suggested by our past president, Dr. Morrison, this committee will be reduced from twelve to nine members, therefore there should be a reduction in expense. We think that $29,000 should be sufficient for expense.

Item 25, Other Committeees—$20,000 requested, in spite of the fact that only $17,000 was spent last year. We have no reason to believe that $3,000 more should be needed this year, therefore we recommend that the amount be kept at $17,000.

Item 26, Department of Public Relations—$60,000 was spent last year and $70,000 was requested for this year, representing an increase of $10,000. We feel that Item 17-d, Conference of Physicians and Schools, in the amount of $6,200, comes under the head of Public Relations, consequently we recommend that the amount under the heading Department of Public Relations should be left at the expenditure of last year, which is $60,000, that if the

amount of $6,200 was considered under Public Relations then the deduction amounts to only $3,800 instead of $10,000.

Item 27, Public Policy and Legislation. In considering that perhaps more money may be needed we realize that the State Legislature is in session this year, and in view of the large number of major crises in sight we believe $70,000 should be enough.

Item 29, Contributions to Medical Libraries. This committee recommends that $6,250 is rather a small contribution to our two big libraries. Because of deficits we do not feel justified in raising it; however, we recommended an increase in this amount shall be seriously considered by the Council in making out the budget for 1957.

Item 31, Contributions to Medical Education. This amount of $130,000 is dependent on increases in dues by $10 per year. The committee feels strongly that this should be done and apparently those that attended the hearing felt the same way. We think that there is no question but the Medical Education program should support our medical education and it is our opinion that the California Medical Association should be in the vanguard of this support move.

Item 32, Committee on Malpractice Insurance. This is a new committee and will require compilation of statistics and services of an insurance actuary. We realize the importance of this work and we believe it should go forward. $19,000 is budgeted but we feel that $17,000 would be sufficient. There is another side on that; we think that it should be first brought up before the Council.

Now $14,000 might be sufficient, but we were afraid it wouldn't be, so added another $5,000 to it, and without any particular reason we could see, so we considered $17,000 would be sufficient.

By that recommendation we decreased the budget —it would show a deficit of $13,580 instead of $45,-117; however, if the profit of $14,550 from CALIFORNIA MEDICINE were considered we'd show a surplus of $970.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

SPEAKER CHARNOCK: This portion of the report, including some ten changes in the budget, as presented by the Council, has been moved and seconded. Is there any discussion? Dr. Bender, of San Francisco.

DR. WILLIAM L. BENDER (San Francisco): Mr. Speaker, members of the House: Misery loves company and I feel very much better than I did last year when I presented two resolutions designed to cut down the expenses of the California Medical Association without impairing any of the important functions of C.M.A. To preach economy always is to become unpopular. Last year I stood up to the big brass hats alone, and now I am very pleased to note that we have a responsible reference committee dealing on the same subject.

We have increased the dues by $130,000 annually by assessing each member $10 more per year. We have nearly balanced the budget, at least, by the suggestions of the Reference Committee. The income from CALIFORNIA MEDICINE of course is a bookkeeping item. Actually the C.M.A. subsidizes CALIFORNIA MEDICINE by transferring to CALIFORNIA MEDICINE $3 per member, roughly $39,000 a year. Of course for that you get your journal, which is a good investment, but at the same time it is difficult to call that income for CALIFORNIA MEDICINE and therefore a profit. Actually, even including that we still have a deficit of about $15,000 even after the changes that the Reference Committee has suggested.

In my book before you increase anyone's dues you prune your expenditures to the bone consistent with continued effective operation of your organization. Last year I presented factual evidence to show that we were indulging in extravagances which could be eliminated without sacrificing the services which those additional expenditures afford. That still is true and it is my earnest hope that this trend to a sound management of the California Medical Association is continued.

SPEAKER CHARNOCK: Thank you, Dr. Bender. Dr. Drummond.

DR. DRUMMOND: I'd like to point out one very encouraging fact. Just a few years ago the California Medical Association was spending only between 5 and 8 per cent of its income for scientific purposes. The rest of the expenditures went for public health, for political activities, and for things that were definitely not scientific. I note now, making a quick and rough calculation, that about one-third of our expenditures are for scientific purposes, which I think is far more worthy of the things for which the grand organization was founded.

SPEAKER CHARNOCK: Thank you, Dr. Drummond.

Are we now ready to vote on this budget? Is there any discussion?

. . . The motion was put to a vote, and carried.

DR. HILL: Your committee has given due consideration to Resolution 17 submitted by Dr. Dave Dozier, which you have before you. There was a great deal of discussion concerning the allocation of the $130,000 for Medical Education. Dr. Dozier believes that the whole amount should be allocated to the three nonland-grant schools in California. Dr. Eugene Hoffman feels it should be distributed in the proportion of 75 per cent to the nonland-grant schools and 25 per cent to the American Educational Fund, to do with as directors see fit. Others thought it all should be given to nonland-grant schools, that some state-supported land and nonland-grant schools should be included. Your committee felt the California Medical Association should indicate its support to the present system of medical education without the interference of the federal government. We also feel that support should not be limited to California only nor to land grant schools

only, but to the whole system of medical education, regardless of the status of the institution, and that the fund be distributed according to need by the A.M.E.F. We therefore recommended that this resolution *do not pass.*

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

SPEAKER CHARNOCK: That section of the report has been moved and seconded. Any further discussion? Dr. Dozier.

DR. DOZIER: I would like to speak to this subject under two titles. One is urgent need and the other is overall policy. In proposing this resolution my own personal feeling was that this not be made a matter of permanent policy and I stand ready either to offer or accept any amendment that would secure that as an integral part of the resolution. That is a matter to be decided this year this way, perhaps a year from now another way.

One of the reasons that I have this feeling on the matter is that as the money was distributed last year, the medical schools throughout the country got variously somewhere between fifteen hundred and perhaps forty-five hundred each, depending upon size of enrollment, whether a two-year school or four-year school, and so forth and so on. In many instances—and I know of one instance in particular—money given by the C.M.A. was absolutely wholly unappreciated by the school. By that I mean they were given a round sum from the American Medical Education Foundation and nowhere in that grant was it indicated that the doctors of California had given that particular portion of the grant that they got, whatever it might be.

This thing is new. Very few of the 48 state societies have adopted a policy like this. They are all feeling their way and if we start in earmarking it one year one way and Illinois in retaliation makes it another way, we are going to get a bifurcated situation on our hands in no time. I repeat, as a matter of overall policy I would not want to have the House feel that that was what this resolution would suggest or portend.

Let's take it rather as a matter of the immediate situation and immediate practicality of the situation, which brings me to the second heading, and that is *need.* If we again consider some fifteen hundred or two thousand dollars, or something like that that each medical school gets, that doesn't keep a medical student in school for a year; sure some nice kid in each school that should be kept in school, I know that, but from the standpoint of budgetary problems of the school such a small gift doesn't go very far and doesn't represent very much. Proportionately, at least, I think it is not greatly appreciated; therefore, let's look at it from the standpoint of need.

I have here a telegram from a president of the Alumni Association of the University of Southern California, Dr. Howard House: "Dr. Donald Charnock, Speaker of the House of Delegates: Previous commitments make it impossible for me to appear before the House of Delegates on the resolution . . . money contributed for Medical Education Fund. Everyone interested in the private schools in California is aware of this, that if our system of free enterprise in the practice of medicine is to survive and our California private schools continue to exist and be made strong, that money made by doctors practicing in California and given to the Medical Education Fund through their own California Medical Association should remain in our state to help our private medical schools in their crucial fight for survival. I sincerely hope the House of Delegates will act . . . on this resolution. Signed, Howard P. House."

I reiterate the words, "urgent need." I think our colleagues from the southern part of the state are aware of the very serious, critical situation in the University of Southern California Medical School. I am sure those of us at Stanford feel that any monies we can get or any appreciable sums are most urgently needed; therefore, it would seem to me that as a temporary measure this proposition has merit.

Your reference committee chairman did not add that when we discussed this before the committee the other day I said I personally would be willing to accept an amendment to this resolution providing that, say, 75 per cent of this $130,000 odd dollars go to our local nonland-grant medical schools and that the other 25 per cent go either unearmarked or for nonland-grant schools throughout the country.

We are feeling our way; this is relatively new. There are indications that this is a problem that is going to rise to the level of the American Medical Association and the whole thing may well be taken out of our hands within the next two or three years. Therefore, on the basis of this year, 1955-56, as a matter of urgent need, as a matter of doing it now, with no thought that it be a permanent policy, because we don't have that kind of knowledge or wisdom, I would like to urge that the committee's recommendation be in fact denied. If any of you care to amend the resolution that has been presented to earmark funds, as I have suggested, or an additional amendment to limit the time, I would most gratefully accept those because I am thinking now of the urgent need of our own schools. (Applause.)

A MEMBER: Mr. Speaker, I rise to a point of information. I am sure other members here would like to know the answer to this question if anyone has the answer. I have tried to find out from the Medical Education Foundation without success. Funds are contributed for medical education in three ways, either unearmarked to the Medical Education Foundation or to the Medical Education Foundation earmarked for a particular school, or by the individual direct to his school. What I'd like to know is whether the amount of money contributed directly to the school or the amount of money

which goes to a school because it is earmarked for that school has any influence upon the allocation of funds from the General Fund's unearmarked money that is given to the Medical Education Foundation.

SPEAKER CHARNOCK: Ask Dr. Green the answer to that.

DR. GREEN: Mr. Speaker, members of the House: I hate to take this microphone year after year in the same problem which is not only a problem in the state of California and before our House, but a problem in all the states, and in all the houses, and with all the graduates, no matter where they come from. I will answer the member's question in this way: all earmarked funds that go to the American Education Foundation are sent to that school without any deductions for administrative cost or anything else. When I say University of Illinois shall get fifty or a hundred dollars they get fifty or a hundred dollars. Does that answer your first question?

A MEMBER: No, the point is that if they get fifty dollars of earmarked funds, do they get fifty dollars less of unearmarked funds?

DR. GREEN: No, not at all, they participate on the same basis as others in every respect, except sometimes as to need that has been decided by the Executive Committee in handling this fund; at other times it depends upon the enrollment. For instance, if the University of Ohio has more matriculates than the University of Nebraska, they get more money accordingly; we have it on the basis of need here, as you can see. I have a whole sheaf of letters from all over the country, from medical schools. Gentlemen, they all need money, there isn't a single one that I know of that does not; possibly Harvard.

There was a time the University of Oklahoma, too, didn't need the funds; whether they need them this year I don't know. It varies from year to year; even the state tax operated schools tell me. At University of Illinois, the Dean tells me, "Doctor, of course we have the state's money to run our medical education program, but," he said, "it drops at various times; we run into an emergency and need a new speaker, we want to acquire an especially good man from some other institution who looks good and can't be employed, or we need a few dollars for laboratory equipment and have to wait until the legislature meets again before we get it." I think we could argue the point all afternoon; in the Medical Foundation group they argue it all afternoon and don't get anywhere. My reply is that you give $130,000 to Medical Education.

SPEAKER CHARNOCK: Dr. Cass.

DR. CASS: I would like to ask Dr. Green or Dr. Murray to tell the House for my information whether or not there is any difference between the amount of money allocated to those state institutions such as University of California, backed by the entire tax resources of the state, as compared to a private institution that has no such backing. Is there a differentiation in the amount of money given to the privately supported or tax supported schools as it has been in the past? Dr. Murray, you are chairman of the Board, you answer that.

DR. MURRAY: Mr. Speaker, Mr. President, members of the House: A direct answer to Dr. Cass' question is no, there is no differentiation between tax supported and nontax-supported schools in the distribution of the fund. The only difference is made in the distribution as Dr. Green pointed out. If this money was allocated directly to the schools in California that means there will be that much less in the General Fund for distribution. Does that answer the question?

DR. CASS: Thank you, Dr. Murray.

DR. HOFFMAN: Yesterday we were asked to find $130,000 odd dollars; our committee has suggested we spend the money on the basis of need, strictly on a policy basis of need. Need has to be decided at the A.M.A. level. The Foundation or the different deans—if we allocate this amount of money on the basis of need we are complicating our donation, we are putting strings on it, we are saying to those men, go find out how it can be allocated according to the greatest need. That means conferences, it means letters, it means hours and hours of committee work and I don't think it is fair to allocate this money on that basis, I would like to see the committee's recommendation voted down.

Now as to the second part, as to how it is to be allocated, I have no pride of authorship in 75/25 per cent. It was suggested to me and was merely a part of the discussion. Neither do I have any opinion, any staunch opinion as far as argument is concerned, as to the resolution as presented to the committee, but I would ask you to vote down the recommendation of the committee. Thank you, gentlemen.

SPEAKER CHARNOCK: Any further discussion?

DR. J. HAROLD BATZLE (Riverside County): I would like to propose an amendment to Resolution No. 17. Before reading the amendment I would like to say why. First of all, I am not a graduate of the schools of California; I am a graduate of a school from the Middle West. Secondly, I am from a state supported school; I have no axe to grind.

I noted in our budget today that 10 per cent of your budget is allocated for public health, and yet we are spending 20-plus per cent for the Educational Fund, and it seems to me that that 20 per cent is losing its identity so far as we are concerned and that we might use it in an effort to regain a little of that in the way of public relations.

Now there is no precedent in establishing this 75/25 per cent suggested because that is the usual way in which fund raising drives are run. Any national organization such as the March of Dimes, for example, starts locally to try to raise funds and they assure the givers that up to 50 per cent of the money that is raised will be used locally. We all know as a matter of fact that in doing it, that is how we provide an incentive for raising funds. After all, charity does begin at home.

In the second place, the money has lost its identity, that hundred thirty thousand dollars that is sent to a fund to be distributed and which is distributed. I am surprised the question wasn't asked, when the $2,000 is given to the school, is it told that that money has been given by the California Medical Association? The answer is no; it is being given by the American Medical Education Foundation. Selfishly, I'd like to have it known I gave the money.

My resolution is in two parts, and reads as follows, if you can follow the reasoning behind this: First, that any funds contributed by California Medical Association be earmarked as restricted to 80 per cent for nonland-grant schools located in California, and 20 per cent to the A.M.A. General Fund; and second, that a study be initiated to consider the advisability that the funds so appropriated for nonland-grant schools located in California be used to establish chairs or professorships in the respective schools in California and that such chairs and professorships be titled as representing the California Medical Association.

SPEAKER CHARNOCK: You put that as an amendment, Dr. Batzle, to the Reference Committee No. 2's report?

DR. BATZLE: I am very sorry. I'd like to apologize if I am out of order. I'd like to propose it as an amendment, yes.

DR. ASKEY: Mr. Speaker, members of the House of Delegates: There are two or three aspects of this problem that we must look at. In the first place we must look at the problem as citizens of the state of California. We are all citizens of this state and we are proud of it. We therefore have a duty to support the institutions that are controlled by our state government. That is being done by each one of us paying our taxes, and your State Legislature disposes of those taxes in relation to its appropriate place.

We have a Board of Regents of the University of California that decides how much goes to our medical schools, therefore as citizens our duty is to see that the tax-supported institutions are taken care of thereby. There we would argue as to how the state taxes are sent to medical schools, as citizens of this state that should go to the Legislative Committee.

As doctors of medicine, however, we have another duty, and that is this, to see that the education of our medical students is adequate, no matter where it is, because, gentlemen, you cannot predicate the assumption that all the men in this room or in this state practicing came from a California nontax-supported institution. I did not; I came from an eastern private medical school, yet I am practicing here. I was interested yesterday to hear that in the University of Illinois—I think it was Illinois—that the Dean said that he had 75 California students at this Illinois institution which was an Illinois state tax supported institution, and they had only 57 from the state of Illinois.

Now it seems to me that when we commence to say that we will allocate the money only to the schools of California we are not doing the correct thing. Now the American Medical Association established the American Medical Education Foundation to distribute this money for the need of medical education. I am going to mention a state, not because it is a true state in fact, but as an example, say the University of Arkansas. I don't know whether it is rich or poor but suppose some of their graduates come to California and they need money and they can't give them an adequate education.

Yes, we are hurting our own practice of medicine by limiting an idea that we may have as to what is most needed. I believe and I hope the chairman of the committee will correct me, that his recommendation is that the fund be allocated as to need, with your recommendation, to the American Medical Education Fund, that they be given according to need and I think that if we do that and send it to the American Medical Education Foundation with our indication that we want it to go to the place where it is needed that is what we should do.

Now a third aspect of this, and thinking of the fact that you might want to give it to your own institutions, the American Medical Education Foundation has stated, as Dr. Pete Green told you, that you wanted it to go to U.S.C., Stanford or any of these other institutions we are proud of, you have the right to say you want it to go to Stanford, therefore the whole three aspects are covered. I think if we carry it out that way we are doing the thing for medical education, you are doing it for the boys who are going to practice here, going to do it for the institutions of those of us who came here, and going to carry out your duties as citizens of the State of California. Thank you.

SPEAKER CHARNOCK: Thank you, Dr. Askey.

DR. WILSON: Mr. Speaker, members of the House: Two points. The first is, we are being taxed by the state to support the two state medical institutions of this state as are citizens of other states taxed for that purpose. For this particular fund we are being taxed by our association to this extent. On the other hand, we look upon it as a gift, and it seems to me we therefore have a right to say where this gift is to be spent. It seems to me it is a mistake for us who as citizens support state medical schools, for us to tax ourselves to support those same institutions. I feel very strongly we should use these funds for the support of those medical schools and institutions which are not largely tax supported; whether in California or across the country makes quite a little difference, too.

The second point which I think we should seriously consider in this matter is that the competition between the private medical schools and the state medical schools is what makes each one great. We are witnesses to that here; we witness that here in San Francisco in the relationship between Stanford and the University of California. Those of you who live in the southern part of the state are seeing the same thing there, now that the U.C.L.A. Medical School is beginning to develop. The U.C.L.A. is

beginning to get born because of the competition. It is going to be forced to become a great school, which it will over the period of time, so we are getting double use out of our money if we will give it to those institutions that can't go to the state for financial support.

DR. GREEN: Mr. Speaker, just so we might know exactly what we are doing in the matter when we decide about the amount of money, I just want to state how it stood last year. We gave a hundred thousand dollars from the Council's sinking fund, safety fund you might say, and we raised by voluntary subscription in California less than $85,000 from our total membership. Here is the grant for California's College of Medical Evangelists, Los Angeles, $33,643.90; University of Southern California School of Medicine, Los Angeles, $24,598.52; Stanford University School of Medicine, San Francisco, $26,860.92; University of California School of Medicine, San Francisco, $24,939.34. I think if you add those figures up you will find out we are just about even.

SPEAKER CHARNOCK: Dr. Graham, Los Angeles County.

DR. GRAHAM (Los Angeles County): I speak as vice-president of a medical school. We have close to six hundred men practicing in California. I know the gentleman who spoke a few minutes ago proposed an amendment to the resolution. I am against the report of the committee, Reference Committee 2, because I have been taxed and taxed plenty to support the state institutions. One of the medical schools in Los Angeles has $65,000 in the bank while U.C.L.A. takes quite a few million dollars from our taxes.

I believe frankly that a certain amount of that money, at least the greatest portion of that money, should go to our institutions here in California and I mean the nontax-supported medical schools. We are complaining, everybody is yelling about the fact, and the liberals say we do not allow our young boys to go to medical school. I am in favor of that 80 and 20 per cent, I'd like to second that amendment, since nobody has seconded it.

I don't believe we should give on the matter of need because I remember perfectly well not very many years ago when President Truman came to Congress and said he wanted the point-four program. The Senate had several bills, and it was going to be given on a matter of need, and at the same time we were buying potatoes from Canada while burning our potatoes in this country. If we are going to be consistent in our policy of giving something to our medical schools, let's give it to those that are not under tax and government supervision. I'd like to second the amendment that the gentleman proposed.

SPEAKER CHARNOCK: Dr. Batzle, from Riverside, California, was the gentleman. Dr. Ogden.

DR. RODERICK A. OGDEN (Kern County): As has been ably stated before, I feel that we support our state schools. The plight of the University of Illinois is actually a little bit cold. It would seem to me that an institution backed by the resources of the state of Illinois, if it is in a position where it can't hire a professor, doesn't have a few thousand dollars for laboratory material, that is a matter of public relations between its chancellor, president, board of trustees and the State Legislature. The money is available if they don't have it at this time.

None of us at any time has seen a state-supported institution with adequate facilities, or anything else, or that had enough money. If you ask anybody in any state-supported things if they have got money, they haven't; they want more. The private institutions are in a bad way. If you want to get down to cases it might be suggested that if it wasn't for the subsidized state of Illinois, for the ball team, your Rose Bowl might do better. I am not in favor of any revision at all. I would suggest that in California, at least, consideration be given that it all be adopted as it is with the exception that it be earmarked for nonland-grant schools of medicine. Thank you.

DR. GREEN: May I have the floor for a minute for factual information? I brought this to the hearing and it seemed then it was very pertinent to the whole matter. This comes from Northwestern University, and was written to Mr. Hunton.

"I have noticed in the listing of the gifts to the American Medical Education Foundation designated for the Northwestern Medical School there appears a contribution of $2,430.22, from the California Medical Association. Northwestern University Medical School is tremendously grateful for this contribution; it signifies confidence in its institution.

"As you know, Northwestern is a privately endowed institution, and it might interest you all to know that an analysis of the applicants to our schools in the academic year of 1952 and '53 it was found we received applications from 44 of the 48 states; 275 applications from the state of Illinois, and 203 from California."

DR. PAUL BOCK (Pasadena): I speak to you as an officer of the Stanford Medical Alumni Association. I wish to point out Dr. Dave Dozier who introduced that resolution was a recent governor of the Stanford Medical Alumni Association and recent past president. He is tremendously well informed and acutely aware of the rather drastic financial problem faced at the present time by not only Stanford, but U.S.C. and College of American Evangelist Medical Schools. It seems to me 13,000 members of the California Medical Association would react a great deal more favorably to increases in their dues of $10 a year if they were assured it was to be distributed to medical schools in their home state who were really in need and whose very existence is being jeopardized by financial restrictions. Thank you.

SPEAKER CHARNOCK: Dr. Batzle, will you state your first proposition, or correct me if I am in error, that your amendment is to read that 80 per cent of the sum contributed by the California Medi-

cal Association of the total American Medical Education Fund shall go to nonland-grant schools in California, or nonland-grant schools, period.

DR. BATZLE: In California.

SPEAKER CHARNOCK: That is what I wanted; the parts about professorships, I think we will kind of work out, I hope.

DR. BATZLE: That is a suggestion for study.

SPEAKER CHARNOCK: Is there any further discussion, then? This amendment has been made and seconded, and we will vote first upon the amendment; at this time may we have any further discussion upon the amendment—80 per cent of the funds contributed by the California Medical Association shall be earmarked for nonland-grant schools in California, 20 per cent shall go to the General Fund. Is that all clear to you?

DR. BATZLE: I would like to know whether that amendment was made directly to the report or whether that amendment was proposed as an amendment to Dr. Dozier's original motion.

SPEAKER CHARNOCK: Directly to the report. If the report was accepted all the money would go to the A.M.E.F. without any further consideration; that is my feeling about it. Would Dr. Hill please correct me on that?

DR. HILL: May I talk a little further on what the opinion of the committee was on this? All three were from private schools, and we are all three taxpayers, and we support the two state schools, but it was the principle of the thing. All of the medical schools are in a bad way, the private schools much worse than the state schools.

I understand the University of Mississippi, for instance, is just about on the rocks. Mississippi is not a really wealthy state and has great difficulty in raising money. We talked it over very thoroughly whether it should be allocated to nonland-grant schools at all. It was finally decided that in the medical profession there has been great criticism of us because we have not supported our present system of medical aid by our present system of medical education.

We do not mean private schools or tax supported schools, we mean the whole system, and that is the purpose of this recommendation. We consider the California Medical Association should indicate its support to our present system of medical education regardless of school but to the whole system, that we feel this indication of support should not be limited to California, shouldn't be limited to the private schools in California, shouldn't be limited to the state schools of California, shouldn't be limited to the schools in any one state, but I want the expression of an indication that California medicine, the medical profession in California, is behind our present system of medical education regardless of what school they come from.

Now that is a clarification of the committee; they say we are all for the private schools.

SPEAKER CHARNOCK: First is on the amendment. Now let's get this quite clear. Reference Committee No. 2 has recommended that Resolution No. 17, granting this money to nonland-grant schools in California, be defeated. If you vote in favor of that, the money, the $130,000, will go to the A.M.E.F. uninstructed. The amendment earmarks that such money shall go 80 per cent to nonland-grant schools in California and 20 per cent to the General Fund—that is the amendment. Are you ready for the question?

MEMBER FROM THE FLOOR: How about Part 2?

SPEAKER CHARNOCK: Part 2 is setting up a study about institutions, professorships, and has not anything to do with the allocation of money which I think you are all interested in at the moment.

Those in favor of the resolution will signify by saying aye.

MEMBER FROM THE FLOOR: The amendment?

SPEAKER CHARNOCK: I am in error, I meant those in favor of the amendment by Dr. Batzle will signify by saying aye. The chair is in doubt. Will those who are in favor of the resolution please stand? All right, those who are opposed to the amendment will please stand. The amendment is passed.

We will now vote on the recommendation of the Reference Committee No. 2, as amended. Those who are in favor of the report of Reference Committee No. 2, as amended, 80 per cent and 20 per cent, will signify by saying aye. It is passed.

Dr. Hill, you may make your recommendation.

MEMBER FROM THE FLOOR: I rise to a point of order. According to this vote we have just had we defeated this resolution that we have just amended, is that right?

SPEAKER CHARNOCK: No, sir, what you have done is defeat the resolution of Dr. Dozier which would put all the money into the nonland-grant schools of California. You have decided to put the money, 80 per cent to nonland-grant schools in California and 20 per cent to the General American Medical Education Fund. Dr. Hill.

DR. HILL: Mr. Speaker, I move the adoption of this report as amended as a whole.

... The motion was seconded.

SPEAKER CHARNOCK: Thank you, Dr. Hill. This report as amended will now be voted upon. Any further discussion? Those in favor of accepting this report as amended will signify by saying aye. Contrary minded?

... The motion was carried.

SPEAKER CHARNOCK: We want to thank Dr. Hill, Dr. Henry Gibbons, Dr. Robert J. Moes.

VICE-SPEAKER BAILEY: We will now have the report of Reference Committee No. 3, Dr. Helen Weyrauch.

DR. HELEN B. WEYRAUCH: Mr. Speaker and members of the House of Delegates: Your Reference

Committee No. 3, composed of Dr. Arthur A. Marlow, of San Diego County; Dr. Robb Smith, of Fresno County, and Dr. Helen Weyrauch, of San Francisco, chairman, has considered all of the resolutions referred to it and would like to submit the following report.

Resolution No. 1—Introduced by Dr. Donald D. Lum for the Council. The Council wishes to restore the older name, Immune Globulin (Human) to a product which has been in use for many years, in place of the new specific name which is misleading. Your committee recommends that this resolution *do pass.*

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded this portion of the report be adopted. Any discussion?

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 2, introduced by E. C. Halley, of Fresno County.

This resolution deals with charges for hospital services and while we are in accord with the intent of the resolution that charges should reflect accurately their source of origin, we feel the purpose will be more clearly defined by this substitute resolution:

"*Resolved,* That the California Medical Association place on record that it believes hospital charges should be maintained at as low a level as is compatible with good medical care; and be it further

"*Resolved,* That a realistic cost accounting system be developed whereby cost of room and board, and service rendered by each department of a hospital be reflected in the patient's bills in their true proportion; and be it further

"*Resolved,* That a copy of this resolution be officially transmitted to the California Hospital Association urging and encouraging that Association to help correct the existing situation as to charges for hospital service."

Your committee recommends that this substitute resolution *do pass.*

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded this substitute resolution do pass. Any discussion?

DR. HALLEY: Mr. Speaker, members of the House, I introduced that resolution from Fresno County and before it was introduced it was surveyed critically by members of the Sixth Councilor District and they accepted it in principle. In that Reference Committee No. 3 has retained the full meaning and intent of this resolution in the resolves that were read here today to you, our county is very happy to accept the substitute resolution and we would urge that you abide by the recommendation of Reference Committee No. 3 in this instance.

VICE-SPEAKER BAILEY: Thank you, Doctor. Any discussion? We then vote on the adopting of the substitute resolution.

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 3, introduced by Malcolm Todd, Los Angeles County.

Your committee thinks that any group should have the opportunity to rediscuss a ruling of the Judicial Council of the A.M.A. when it concerns a change of status. However, we have clarified the wording of the fifth "whereas" as follows:

"WHEREAS, The dispensing of glasses is only incidental to the rendering of service," and on the copy submitted to this committee the eighth "Whereas" was deleted by the author but through error it was reproduced on the copy you have in your hands. This deletion should be made on your copies—No. 8 Whereas.

VICE-SPEAKER BAILEY: What does it start with?

DR. WEYRAUCH: Whereas, any interpretation of ethics which prevents an ophthalmologist—

VICE-SPEAKER BAILEY: That is enough; just wanted to be sure everybody knew what it was.

DR. WEYRAUCH: We have deleted several phrases in the resolved so it now reads:

"*Resolved,* That the House of Delegates of the California Medical Association instruct the California delegates to the American Medical Association to reopen the discussion of the present interpretation regarding the ethics of rendering a complete dispensing service by physicians."

Mr. Speaker, your committee recommends that this amended resolution *do pass.*

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded to adopt this portion of the report. Any discussion?

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 4, introduced by Dr. T. D. Englehorn of Monterey County.

Your committee feels that this resolution dealing with laboratory advertising merits consideration. We have changed the wording slightly in the first and last "Whereas." The first Whereas shall read: "Whereas, professional advertising in medical society bulletins and other publications is not considered an ethical practice," and the fourth Whereas shall read:

"WHEREAS, The acceptance and publication of such advertising by lay laboratories creates an unfair advantage in favor of a nonmedical person not generally available to the doctor of medicine; now, therefore, be it

"*Resolved,* (1) That this House of Delegates recommend to each county medical society that any

notice or announcement by a lay laboratory that is printed in a county medical society publication be subject to the same restrictions that apply to similar announcements by doctors of medicine."

Section (3) would then be number (2), and the new section (3) would read as follows:

"(3) That copies of this resolution be sent to all component medical societies of the C.M.A."

Your committee recommends that this amended resolution *do pass.*

Mr. Speaker, I move the adoption of this section of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: The motion has been made and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 5, introduced by Lewis T. Bullock of Los Angeles County.

This resolution regards the distribution of income from charity events. While your committee is in accord with the principles expressed in this resolution, having ascertained that Assembly Bill 2925 covering this situation has passed the Assembly and is expected to receive favorable action in the Senate, we feel that this will accomplish the purpose of the above resolution. For this reason your committee recommends *do not pass.*

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion? This is a negative resolution, this "do not pass." An affirmative vote will kill the resolution.

... The motion was put to a vote, and carried.

DR. WEYRAUCH: No. 9, introduced by Herbert C. Moffitt, Jr., of San Francisco County.

Your committee feels that this resolution has many facets and it is wise to have it under Council consideration. Your committee recommends *do pass.*

Mr. Speaker, I move the adoption of this portion of this report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 10, introduced by Herbert C. Moffitt, Jr., of San Francisco County.

This resolution deals with an important problem in the evaluation of products and your committee recommends a *do pass.*

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 11, introduced by Herbert C. Moffitt, Jr., of San Francisco County.

Your committee feels that this is an increasingly important subject and deserves an intensive study and perhaps even a dynamic new approach before the situation becomes acute. Your committee therefore recommends *do pass.*

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 12, introduced by Dr. R. W. Helms, of Los Angeles County.

The committee heartily endorses the concept of free choice of physician. The committee also realizes that the Workmen's Compensation Law is very intricate and for this reason feels that the proper place for study of this resolution lies in a committee dealing with this problem and should be studied therein. We would like to point out that workmen's compensation laws are not new and many states have similar laws. Their methods of meeting this problem should be explored and particular attention should be called to the New York system for providing service for medical injuries. The committee recommends that this resolution be referred to the Committee on Industrial Practice unless the new table of organization is accepted, in which case it should be referred to the Commission on Public Policy.

Mr. Speaker, I move the adoption of this section of this report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. This House will note that is a motion to refer to one of two committees, whichever is most logical, not a motion to pass. Any discussion?

... The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 13, introduced by James B. Graeser of Alameda-Contra Costa County.

Your committee approves this resolution and recommends *do pass.*

Mr. Speaker, I move the adoption of this section of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 14, introduced by Frederic P. Shidler of San Mateo County.

The committee appreciates the motives which prompted this resolution. However, after due consideration, your committee felt that a resolution to clarify the status of such plans would be more appropriate at this time and offers this substitute resolution.

"WHEREAS, The California Medical Association has encouraged local component societies to experiment and to develop prepaid health plans; and

"WHEREAS, Without proper advice and supervision such plans may incorporate features which have proven to be unworkable or disadvantageous to either the subscriber or to the physician; now, therefore, be it

"*Resolved,* That the California Medical Association continue to encourage the development of prepaid plans by component societies but that in the development of such plans it is recommended that the advice and counsel of appropriate agencies of the C.M.A., such as the Council or the Medical Services Commission, or California Physicians' Service be obtained."

Your committee recommends that this substitute resolution *do pass.*

Mr. Speaker, I move the adoption of this portion of this report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded the substitute resolution do pass. Any discussion?

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 15, introduced by Dr. E. W. Henderson of Alameda-Contra Costa County.

Your committee finds itself in accord with this resolution and recommends *do pass.*

Mr. Speaker, I move the adoption of this portion of this report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion?

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 16, introduced by J. Philip Sampson of Los Angeles County.

Your committee recognizes the need for the establishment of uniform standards governing the practice of medicine by the faculties of medical schools and similar institutions and therefore approves this resolution. Your committee recommends that this resolution *do pass.*

Mr. Speaker, I move the adoption of this portion of this report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion? Dr. Burt Davis.

DR. BURT DAVIS (Santa Clara County): I should like to point out that that problem is quite a bit larger than that which was indicated by Dr. Culpepper's resolution which I heard presented to the A.M.A. in Miami last November. In that particular resolution Dr. Culpepper was considering the effect on the practice of medicine in Mississippi of the development of a medical school which, as we have heard previously, is a little short of funds, and therefore in order to induce good men to come and work for the medical school they had to be allowed to indulge in a certain amount of private practice.

I am totally in accord with the resolution as it was offered by Dr. Culpepper; however, I feel that his resolution is a little bit restricted. In these days in which we cannot tell exactly where all of the funds for research and all of the funds for teaching come from, the line that delimits a tax supported school and a nontax supported school, whether you are paying taxes through the federal government or the state government or your own county and local government for the maintenance of certain facilities or whether you are paying it through additional dues to your medical society, in these days it is a little bit difficult to define the exact origin of the money that goes for these purposes. Therefore I should like to add the following resolve which would state:

"And be it further *Resolved,* That the Delegates of the A.M.A. from California Medical Association urge the House of Delegates of the American Medical Association to broaden the scope of this study and to examine the entire problem regardless of the tax status of the institution involved."

VICE-SPEAKER BAILEY: You have heard the amendment. Is there a second to it?

. . . The amendment was seconded.

VICE-SPEAKER BAILEY: Now it is open to discussion.

DR. ROBERTSON WARD (San Francisco): Mr. Speaker, I'd like to not discuss the amendment but to discuss the original Culpepper resolution and tell the House of Delegates what it is now, where it is now, and what is back of it.

VICE-SPEAKER BAILEY: Dr. Ward, if we could get this amendment cleared up first it would be a little easier.

DR. WARD: My discussion would be on that. This was turned over to the Council on Medical Education and Hospitals for study and report at the coming session of the American Medical Association House of Delegates. I tried to find out from Dr. Cline before he left here this morning to attend a meeting of that council what action they had taken on it and what we were liable to be called upon to do at the next meeting of the House of Delegates of the American Medical Association. He said the Council had given this a very thorough study and was going to come in with a recommendation that is very much along the line of the amendment to the resolution that Dr. Davis has just introduced, so that I would be in favor of passing this amendment.

You cannot instruct the delegates to the House of Delegates from California to do thus and so because just like this House of Delegates their action is determined by recommendations of the Reference Committee to which that resolution has gone and been debated on the floor. All you can do is to let them know what our sentiments are and to be guided by those in their procedures. I am in favor of the amendment to this report by the Reference Committee No. 3.

VICE-SPEAKER BAILEY: And you are in favor of Dr. Davis' sentiments. That then leaves this amend-

ment for vote right now, unless there is further discussion.

. . . The motion to accept the amendment was put to a vote and carried.

VICE-SPEAKER BAILEY: As a matter of fact we had better take the whole resolution now as amended and it has been moved and seconded. All those in favor of passing the report as amended will say aye.

. . . The motion was carried.

DR. WEYRAUCH: Resolution No. 18, introduced by Dr. Dave Dozier of Sacramento County.

The committee feels that this is a subject worthy of consideration and recommends a *do pass.*

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion? Dr. Morrison.

PRESIDENT MORRISON: Having spent two years at this I would like to make a few remarks about this particular one. I am not even in favor of having it referred to the Council for study and a report coming back. I appreciate very much the sentiment that motivated this but it is my feeling that any person who sat in the House of Delegates and the Council long enough to be considered for these positions knows very well what he is taking on.

I feel not only about this office, but I feel about other key offices in the association, key committee appointments, and so forth, if a man is willing to give his time he should be reimbursed for out of pocket expenses, but certainly would not like to see a stipend attached to this office. To me it would cheapen the honor. Thank you.

VICE-SPEAKER BAILEY: Is there any further comment or discussion? All those in favor of the resolution will say aye. Passed.

DR. WEYRAUCH: No, the "noes" have it.

VICE-SPEAKER BAILEY: It is not so ordered.

DR. WEYRAUCH: Resolution No. 19, introduced by Edgar F. Mauer, of Los Angeles County.

Your committee realizes that the problem of dealing with refuse has become very important in certain areas. There are two committees in the C.M.A. at present interested and working together on this subject and your committee recommends that this resolution be referred to these two committees, namely, the Council's Committee on Public Health and Public Agencies and the Committee on Rural and Community Health.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded, motion to refer. Any discussion? Dr. Mauer back there.

DR. EDGAR F. MAUER: Mr. Chairman, there is a matter of some urgency about getting a policy statement from the House of Delegates regarding this; this is hardly a controversial issue. It simply backs up certain concepts concerning public health and public hygiene and I wonder if I would have permission to reword the original resolution to state it be referred to the Council as mentioned by Reference Committee No. 3 rather than the legislative representative, and thereby gain the support of the delegates of the California Medical Association for our example will be copied in the very near future.

VICE-SPEAKER BAILEY: Dr. Mauer, you may move to amend this; just how are you going to do it?

DR. MAUER: I would like to move to strike out from the resolved paragraph, words, "legislative representatives of the California Medical Association," and insert that, "the Council's Committee on Public Health and Public Agencies and the Committee on Rural and Community Health be instructed to utilize all means," et cetera. That comes very close to what we have here, doesn't it? That is the amendment.

VICE-SPEAKER BAILEY: Is there a second?

. . . The motion was seconded.

VICE-SPEAKER BAILEY: Any discussion?

. . . The motion was put to a vote, and carried.

VICE-SPEAKER BAILEY: We go to the entire resolution. All in favor of the resolution as amended. Any discussion?

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 20, introduced by Dr. E. C. Rosenow, of Los Angeles County.

The committee agrees in principle with this resolution but wishes to amend it to a minor extent. The fifth "Whereas" shall now read:

"WHEREAS, The primary purpose of the pharmaceutical and drug houses is to sell drugs, and although ethical advertising is not to be condemned in any way, a clear distinction between advertising and education is essential; therefore be it

And the second "Resolved" shall now read:

"*Resolved*, That the Council be instructed to take any action it deems necessary to restore the sole responsibility for postgraduate medical education to recognized agencies responsible for medical education." And add a third "Resolved" to read as follows:

"*Resolved*, That the conditions under which physicians participate in programs sponsored by nonprofessional groups be formulated."

The final sentence of the printed resolution has been incorporated into the body of the resolution as a fourth "Resolved" and reads as follows:

"*Resolved*, That the intent of this resolution be introduced by an appropriate resolution before the House of Delegates of the American Medical Association."

Your committee recommends that this amended resolution *do pass.*

Mr. Speaker, I move the adoption of this portion of this report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Dr. Davis, Santa Clara County.

DR. BURT DAVIS (Santa Clara County): I was somewhat surprised that no recognition has been given to the television program, Medic, and I wish to take this opportunity to offer it our congratulations because although we are the state in which most of the work has been done on the program there are five other states in their Houses of Delegates which have felt very kindly toward the project and have expressed themselves appropriately. Therefore I would like to add as possibly Resolved 3-a, or say 3½, or what have you, between the third and fourth resolves of the committee, "And be it further *Resolved,* That the television program Medic, which has been a cooperative effort with the Los Angeles County Medical Society, be commended."

VICE-SPEAKER BAILEY: You have heard the additional resolved, as amended. Is there a second?

. . . The resolution was seconded.

VICE-SPEAKER BAILEY: Any discussion?

. . . The motion was put to a vote, and carried.

VICE-SPEAKER BAILEY: We will take the entire resolution. Any further discussion on it as amended? All those in favor will say aye.

. . . The motion was carried.

DR. WEYRAUCH: Resolution No. 21, introduced by Dr. L. C. Burwell, of Los Angeles County.

The committee feels that hospital accreditation is a very important subject with respect to the patient's welfare. We also feel that the Joint Board of Accreditation is cognizant of this obligation. This Board, which has been in existence for only four years, consists of four medical groups, namely, the American Medical Association, the American College of Surgeons, the American College of Physicians and the Canadian Medical Association, as well as the American Hospital Association.

Your committee feels that four years is not a sufficient time to evaluate the progress of this Board and that we should defer action until a later date. For these reasons your committee feels that we should recommend that this resolution *do not pass.*

Mr. Speaker, I move the adoption of this section of this report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded, do not pass. Any discussion?

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 22, introduced by Sam S. Woolington, of Los Angeles County.

Your committee concurs with this resolution and would like to add the following statement as a part of this committee report.

"*Polio Vaccine Program for Needy Children.*

"This emergency inoculation program stems from the realization that this year there is a gap in local health facilities in Long Beach. Polio vaccinations have been given to first and second grade school children and would not be available to others except from private physicians. The Long Beach Pediatric Society, with the approval of the Long Beach branch of the Los Angeles County Medical Association, therefore organized the following program. It provides polio inoculations of those children whose financial eligibility has been determined by proper screening. Members of the Long Beach Pediatric Society will, of course, contribute their services without charge for giving inoculations.

"Service clubs and other Long Beach organizations were invited to contribute toward the purchase of polio vaccine. The Long Beach Council of Service Clubs agreed to cosponsor the project and handle the fund raising and the details of collecting. The Long Beach Children's Clinic, being an already incorporated, nonprofit, tax-exempt organization, agreed to accept and distribute the funds, establishing a separate Polio Vaccine Fund of the Children's Clinic. The Auxiliary of the Long Beach branch of the Los Angeles County Medical Association and other community volunteer women's groups have offered to furnish volunteer help for the program. It is estimated by local Community Chest officials that 1,000 to 5,000 children will need this service. For this number a goal of $15,000 was set. Eligible families include those on general relief, state aid, disability benefits, unemployment compensation, veterans' pensions, and other low income groups. Eligibility will be determined by screening under the direction of social service workers from Community Chest agencies who are also volunteering their services. Our standards for eligibility are a modification of the standards of the Aid to Needy Children program of California.

"The site for screening and for giving the inoculations in our area will be the Community Chest Building. Dates at which parents of needy families should come to the Community Chest Building to apply for the vaccine have been publicized in local newspapers. At these times, eligibility will be determined and postcards will be filled out for each eligible child. As soon as the vaccine is available, postcards will be mailed giving the date for the child's first injection. It is planned to give two injections three weeks apart. All plans are of course dependent on distribution and allocation of the vaccine. The only limitation to the program would seem to be the amount of vaccine available and the amount of funds raised to purchase the vaccine.

"The Board of Education has approved distribution of a letter to parents of first and second grade children who are receiving the polio vaccine injections in schools without charge, offering an opportunity to these families to contribute to the Polio Vaccine Fund. Mr. H. Burmester, and Mr. Sam Cameron of the Long Beach *Press-Telegram* arranged for their paper to underwrite the printing expenses and postage involved in preparing the let-

ter and self-addressed envelopes to be sent out through the schools.

"Long Beach doctors are confident that this program is effectively fulfilling the need in this area to provide polio vaccine injections to children whose parents desire this service and are unable to afford it. We have prepared this detailed account of the organization of our local program so that doctors from other areas of the state can quickly organize a similar plan if no such facilities are now available in their communities. Doctors desiring further details may contact any member of the Long Beach Pediatric Society Committee."

Mr. Speaker, we recommend that this resolution and statement *do pass.*

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion? Dr. Ward, would you care to discuss it?

DR. WARD: This is a very timely program. I don't know whether you can all read the headlines; the headlines don't tell the story. I am up here, of course, to make a plug for this resolution and the added data that Dr. Weyrauch's committee has given so that any committee in California knows just how to organize to see that the needy children get their polio vaccine. The headlines say, "Ike backs polio shots in schools for free." I would like to read you the first line of this article which completely denies the headlines and it says, "President Eisenhower said today, 'No American child is going to be denied the Salk polio vaccine because of inability of his parents to pay for it.' " That is what the paper calls for free.

This is a very timely program and I hope that it has your support. I am sure it will.

VICE-SPEAKER BAILEY: Thank you, Dr. Ward. Dr. Dwight Wilbur.

DR. WILBUR: The Council is concerned with the statement on the question of polio vaccine and will consider it at the conclusion of the meeting of the House of Delegates. I am not sure what that statement will contain; possibly there might be a slight conflict between the action or rather recommendation of the committee and the statement of the Council. I would like to suggest, therefore, that an amendment be made to this motion that the resolution and the accompanying statement be referred to the Council and then, with the understanding that the Council will have to sell the House of Delegates on this matter. Then, in its statement there will be no conflict between that which the House of Delegates makes with regard to this letter and that which the Council makes with regard to the whole problem of polio vaccine.

VICE-SPEAKER BAILEY: Is there a move to refer for the purpose of flexibility?

. . . A motion to refer was made and seconded.

VICE-SPEAKER BAILEY: Any discussion?

. . . The motion was put to a vote, and carried.

VICE-SPEAKER BAILEY: We will ask for the report as amended. All those in favor say aye.

. . . The motion was put to a vote, and carried.

DR. WEYRAUCH: Resolution No. 23, introduced by Owen F. Thomas of Sonoma County.

We find ourselves in accord with this resolution and recommend *do pass.*

Mr. Speaker, I recommend the adoption of this section of the report.

. . . The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded this section of the report be adopted.

DR. WILBUR: I speak again; unfortunately, I was unable to appear before the Reference Committee. I think one problem we ought to give consideration to, that is, there has been considerable difference in the report that was made by the Medical Task Force of the Commission on Medical Services and the commission itself and I believe there are certain recommendations which the commission has made which the American Medical Association does not wholeheartedly endorse. I'd like to suggest two things. First, that Dr. Murray, if he is willing, tell us whether or not this resolution is in keeping with the feelings of the American Medical Association. Second, I would like to suggest an amendment and that is that the House endorse not only the recommendation of the Hoover Commission, as Dr. Weyrauch recommended, with that from the American Medical Association standpoint, but that it also endorse the findings of the Medical Task Force resolution because they are more extensive, in my judgment at least, and much more suitable than those of the Commission alone.

VICE-SPEAKER BAILEY: Dr. Murray, would you care to speak?

DR. MURRAY: Mr. Speaker, members of the House: The American Medical Association, as Dr. Wilbur has pointed out, is not quite in accord with the report of the Hoover Commission itself. Now you understand the Hoover Commission consisted of some task forces, one of which is a medical task force. The American Medical Association has not completed its study entirely but there is strong indication that it is in favor of the report of the Medical Task Force but not in favor of the report of the entire Hoover Commission. So far as medical affairs are concerned, I think the American Medical Association will endorse practically entirely the report f the Medical Task Force of the Hoover Commission.

VICE-SPEAKER BAILEY: Thank you, Dr. Murray. Dr. Wilbur, would you care to change your position? You now endorse the recommendation of the Hoover Commission and also the findings of the Medical Task Force of the Hoover Commission? Would you care to limit it to the latter?

DR. WILBUR: I think the best conclusion would be to recommend the House endorse the report of

the Medical Task Force of the Hoover Commission and leave it to the Council as to endorsement of the Hoover Commission on the federal medical service.

VICE-SPEAKER BAILEY: Is there a second?

... The motion was seconded.

VICE-SPEAKER BAILEY: Any discussion?

... The motion was put to a vote, and carried.

VICE-SPEAKER BAILEY: Then Resolution 23 as amended is before the House. Is there any discussion?

... The resolution, as amended, was put to a vote, and carried.

DR. WEYRAUCH: Mr. Speaker, I am going to take this opportunity to express my appreciation to Drs. Marlow and Smith for their diligent and continuous cooperation in preparing this report and serving on this committee.

Mr. Speaker, I move the adoption of this amended report as a whole.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion on this amended report as a whole?

... The motion to adopt the report as a whole, as amended, was put to a vote, and carried.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Weyrauch.

SPEAKER CHARNOCK: I'd like to make one announcement at this time. The hotel has announced that checkout time shall be any reasonable time, such as between 5 and 6 o'clock, for example.

VICE-SPEAKER BAILEY: We now have Dr. Foster here. I'd like the opportunity of introducing him as your new Vice-Speaker. Dr. Foster.

We now have the report of Reference Committee No. 4, chairman Dr. Dorothy Allen.

DR. DOROTHY M. ALLEN (Oakland): Mr. Speaker, members of the House of Delegates: Your committee consisting of Herbert Moffitt, Jr., from San Francisco; James E. Feldmayer, from Tulare County, and myself, have held hearings on all constitution and by-laws amendments referred to it and make the following recommendations.

Constitutional Amendment No. 1, introduced by Donald D. Lum. Subject: Physicians' Benevolence Fund, Inc.

This constitutional amendment as submitted is approved by your committee unanimously and it now must lie on the table for one year, hence no action taken.

VICE-SPEAKER BAILEY: That requires no further action. We will proceed to the next by-law amendment.

DR. ALLEN: By-Law Amendment No. 1. Subject: Reorganization. Introduced by Dr. Donald D. Lum, Committees and Commissions of State Organization. The printed copy is in your hands and there are certain changes, typographical changes that I would like to take up with you.

Under Section 1, Section D, Item No. iii, Cancer Commission, has been deleted and the following three items should then be numbered as iii, iv, and v.

On Page 4 of your mimeographed copy under Section 5, on Line 3, the word "nine" should be changed to "twelve," and the first part of the sentence should then read, "Unless otherwise provided by these By-Laws each of the standing committees listed in Section 1 of this Chapter shall consist of not less than three nor more than twelve members."

With these corrections the amendment will appear as presented by Dr. Lum.

Your committee further recommends the following addition or modification in this By-Law amendment of Section 1-D, the addition of another committee, Committee on Other Professions.

No. 6, Section 3, Paragraph 1, to read as follows:

"Unless otherwise provided in these By-Laws each commission shall consist of not less than five nor more than nine members, the number of members of each commission being determined by the Council, however, the number of members of each commission may be altered outside of the foregoing limit by the Council from time to time."

Section 3, Paragraph 3, the following sentence to be added: "The Commission on Public Policy shall be composed of members of the Legislative Committee and members of the Public Relations Committee."

Section 11, the heading to read as follows: Publication of Commission and/or Committee Reports." The same insertion of "or" to be made in the first line so it will read, "Reports of the Commission and/or their standing Committees, and the report of Special Committees, as approved by the Council, shall be published in a brief preconvention bulletin or in the official journal."

The last paragraph of the resolutions to read as follows: that "Section 6 of Chapter IV of the By-Laws of this Association is hereby repealed with the former Section 7 being renumbered Section 6."

Your Reference Committee is pleased to note that the Commission on Medical Services will include sub-committees, thus will be implementation with respect to the health insurance requested by this House by its unanimous passage of Resolution 26 of last year.

Your committee recommends that this amendment *do pass*.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: The chair believes that the intent of the By-Laws has not been changed by these suggestions and therefore suggests that it is in order to proceed on this right now. It has been moved and seconded that this do pass. Is there any discussion?

... The motion was put to a vote, and carried.

DR. ALLEN: As you can see, the passage of the Amendment No. 1 makes Amendments Nos. 2 and 3

unnecessary. They have been taken care of in the passage of No. 1.

For expediency may we take you to Amendment No. 5 before taking up No. 4. Amendment No. 5 is introduced by Dr. Moffitt. The subject, Separation of Eye and Ear, Nose and Throat sections.

Your committee recommends a *do pass* on this amendment.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded.

... The motion was put to a vote, and carried.

DR. ALLEN: No. 4, introduced by Homer C. Pheasant. Subject, Section on Orthopedics.

Your committee recommends a *do pass* with the following changes:

"*Resolved*, That Chapter IV, Section 1(a) of the By-Laws be amended by adding 'Orthopedics' to the list of Scientific Sections and by changing the number of Scientific Sections from fifteen to seventeen."

The committee urges that there be close cooperation between the two sections, namely, Orthopedics and the Industrial Medical and Surgical Section, close cooperation between the two sections on planning their scientific sections.

Mr. Speaker, I move the adoption of this section of the report.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. ALLEN: Mr. Speaker, I move the adoption of this amended report as a whole.

... The motion was seconded.

VICE-SPEAKER BAILEY: It has been moved and seconded the report be accepted as a whole. Any discussion?

... The motion was put to a vote, and carried.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Allen.

SPEAKER CHARNOCK: The next order of business is report of Committee on C.P.S. business, Dr. Kilroy, Sacramento, chairman.

DR. KILROY: Mr. Speaker, members of the House: Your C.P.S. Reference Committee, consisting of Dr. Frederick Ewens, Dr. Fred Olson and myself, has reviewed the report of the President of C.P.S. Board of Trustees. No detailed discussion before this House will be rendered by your committee—but several items within the report merit additional comment.

Your committee has noticed a satisfactory growth in subscribing membership and we could encourage a comparable increase in the coming year. Your committee noticed with interest the thinking on the part of C.P.S. in relation to forms of prepayment other than the service type of plan. It is the feeling of this committee that C.P.S. business continues to show the most benefit inherent within these various types of insurance plans and should never be content with an attitude that one plan alone answers all of the needs of the public.

Governmental agencies are now and have been investigating ways and means for the covering of those groups heretofore considered uninsurable by private insurance companies. We feel that C.P.S. should carry out a continuing study leading to the development of plans whereby that group can be insured without looking to government for assistance.

Your committee read with considerable interest that section of the report dealing with the indigent program. We recognize the recommended saving in the tax picture in the development of an indigent care program and therefore the committee asked California Physicians' Service to do all within its power to encourage the inclusion of this indigent group under a system of voluntary insurance such as C.P.S. Your committee recommends that the Board of Trustees of California Physicians' Service work in close liaison with the California Medical Association, leading to the formulation of those plans necessary to carry out this recommendation.

Your committee commends the very considerable time spent by the Board of Trustees and its president on behalf of the physicians of California. We commend them on their personal sacrifice on these time-consuming efforts.

We commend Dr. Francis Hodges for the complete nature of the report he submitted.

I move the adoption of this section of the report.

... The motion was seconded.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Any discussion?

... The motion was put to a vote, and carried.

DR. KILROY: Resolution No. 6, introduced by Herbert C. Moffitt, Jr., San Francisco Medical Society.

"*Resolved*, (1) That this House of Delegates direct the C.P.S. Trustees to set up a type of policy immediately which would include deductible and co-insurance, and (2) that C.P.S. be directed to push the sale of this type of insurance immediately with even greater vigor than it sells the present type policy, and (3) that medical fees under C.P.S. indemnity would constitute the normal private fees of the individual physicians which would eliminate the necessity of a fee schedule."

Your committee does not feel that Part 1 of the resolution necessitates action—the intent of this resolution has already been established by a resolution of the House of Delegates two and one-half years ago, saying an indemnity scale was authorized, and last year it was recommended to this body that California Physicians' Insurance Corporation was authorized by the state to do business. In two years all the House authorized the indemnity corporation

to sell were those policies in those counties requesting it and that action was taken by the House two years ago whereby deductible and coinsurance features are available to any county society, subject to the approval of the State Insurance Commission.

Concerning the second paragraph of the resolution, it is not the function of California Physicians' Service to enter into this type of insurance. The California Physicians' Insurance Corporation cannot push the sale of indemnity insurance until the individual county medical society has requested that this type of insurance be sold within its county.

The request made in the third paragraph of the resolution that the normal private fees of the individual physician constitute the payment under an indemnity plan is a subject which merits further thought, as that constitutes an investigation and study of medical insurance plans, your committee therefore offers this substitute resolution:

"*Resolved,* That the Medical Services Commission is requested to study and report on the feasibility of establishing the normal private fees of the individual physician as the medical indemnity payments under California Physicians' Insurance Corporation."

Mr. Speaker, I move the adoption of this substitute resolution.

. . . The motion was seconded.

SPEAKER CHARNOCK: The substitute resolution has been moved and seconded. Any discussion? Dr. James Thompson.

DR. JAMES H. THOMPSON (San Francisco): As author of this resolution it was our original intent to stimulate C.P.S. to do something about indemnity insurance and to recommend that C.P.S. help pioneer combined indemnity and co-insurance type of policy similar to that type of policy being sold in northern and southern California by some private companies at the present time.

As the report now states, it is pointed out that such insurance is available but that local counties have not requested indemnity. It also removes a phrase that recommended that C.P.S. be forced to sell indemnity insurance in those counties requesting it.

Since C.P.S. is a doctor's plan and there is a large group of us that service insurance, the only type of health insurance, I believe, that C.P.S. should actively sell both service and indemnity to show that doctors also like and possibly prefer indemnity. I would like to move that the substitute Resolution No. 6 be changed as follows:

The amendment has an addition at the end of the substitute resolution which will read, "and that selected experimental subscriber groups be started within the year as a practical aid to this study, and be it further *Resolved,* That in counties requesting indemnity insurance which has been approved by the California Insurance Commissioner, California Physicians' Insurance Corporation be directed to sell indemnity insurance with the same interest it is using in the sale of service contracts." Thank you.

SPEAKER CHARNOCK: Is there a second to that amendment?

. . . The amendment was seconded.

DR. CHARLES A. NOBLE, JR. (San Francisco): This House of Delegates voted at its last session to permit the sale of such indemnity insurance policies in those counties requesting it. That permission was of course granted, but the granting of permission and active sale of that insurance are two entirely different things and it is partly because of this that this resolution is introduced. There are two counties, one of them San Francisco County, that requested that indemnity insurance and allowed it to be sold and has requested this of California Indemnity Insurance Company.

It seems to me that it is the responsibility of the leadership of an insurance company to push sales of an insurance when that is requested. Physicians themselves could merely request that certain policies could be drawn up and until that is done it seems to me that the public at large may easily get the impression that because only service policies are being offered by physicians that that is their major choice. I think now that the public at large will be served better and physicians will be happier the sooner it becomes possible to implement the development of such indemnity policies.

DR. CRANE (Los Angeles County): The emphasis of the Reference Committee seems to be on the fact that this indemnity or deductible type of insurance must be requested in order for C.P.S. to push it. As I recall it, when we authorized the $6,000 ceiling we also put a similar tag on it that it was to be requested by the county groups if they wanted it. Now everybody here, I am sure, knows that what has happened with reference to the $6,000 ceiling. That has been pushed, and I am sure not always at the request of the county.

A gentleman from Riverside I spoke to several weeks ago told me that in the process of Riverside County being worked over to this particular deal, the representatives of C.P.S. made the statement to him that Los Angeles County was going to be a tough nut to crack on the $6,000 ceiling, and I am sure that is true. We have been approached repeatedly, the Council of the Medical Society of Los Angeles, repeatedly on the $6,000 ceiling, and I don't recall the Council ever asking for that particular thing.

Now, what these men from San Francisco want and what most of us want is for the C.P.S. lay individuals and the doctors who are working with this thing to put just as much effort into one as into the other and if they don't do that I think it is up to this House of Delegates in the next year to consider very seriously changes in personnel of those groups because if we are dealing with people who are not interested in what we want I think it is time we got people into those positions who are interested in doing what we want.

SPEAKER CHARNOCK: Any further discussion of this amendment? Hollis Carey.

DR. HOLLIS CAREY: Mr. Speaker, members of the House: I have served on the Medical Services Commission, as most of you know, for a period of three years. I don't think you can consider it an inactive group. In the past year, as I reported to you in my special report, we had two meetings in this last past year on the deductible type of insurance. You will remember that your commission gave you certain recommendations in that regard. First, that we were studying this particular type of insurance with a great deal of interest. We do not feel we could put it any stronger than that, that we are watching to see just exactly what deductible insurance means in anything but a highly selected group, which it is at the present time.

Another point brought out by Dr. Crane was that if the people in it who were responsible for the consideration of these things were not active enough he would like to replace them. I think that we have had six meetings of the commission this year. We are working with C.P.S., we are working with the Council; all of these factors have been considered and are being considered. I feel personally that the commission and C.P.S. are moving as rapidly as is feasible and as rapidly as it can economically and soundly move. I think that this action, if taken on the part of this House without the proper background information which is available to us as a commission and which is available to you if you want to attend those commission meetings with us, would be most ill advised.

I think the substitution of your Reference Committee is factual and sound. I would urge you, gentlemen, not to push through resolutions on those things which we do not feel are yet presently factually sound and press us into the position whereby we will have to commit some error of judgment. This must be necessarily slow. I regret that; I am just as anxious as you are to insure every indigent in the State of California if that is possible, but at the present moment the only experiment that is going on in this regard in California has been running for a period of three years. We still do not have all the bugs worked out on that but we hope in the very near future to have supplemental groups set up that will prove the importance and the good or bad of this condition.

As Mr. Hamman has said, as far as C.P.S. is concerned, he is perfectly willing to lose a small piece of his financial shirttail but he doesn't want to lose the whole shirt.

DR. HILL: I rise to a point of information. I would propose a rereading of the proposed committee report.

SPEAKER CHARNOCK: Dr. Thompson, will you come up here and let's get this resolution. Have you a few extra copies? Now, Dr. Thompson, will you reread this please?

DR. THOMPSON: I will read just the addition to the resolution, the substitute resolution which you have. This goes right on with the same sentence, states, "and that selected experimental subscriber groups be started within the year as a practical aid to this study." If I may just deviate slightly, this would be a very select group, very comparable to what some of the private companies are doing. Note that it would be experimental, with action; the fact is that only a small group would entail a large amount of money if these groups went wrongly. We all agree in medicine we have to have some practical trial of our theories and that was the intent of this idea.

"And be it further *Resolved,* In the counties requesting indemnity insurance which has been approved by the California Insurance Commissioner, California Physicians' Insurance Corporation be directed to sell indemnity insurance with the same effort it is using in the sale of service contracts." Thank you.

SPEAKER CHARNOCK: Do you wish to discuss that? Dr. Teall.

DR. RALPH C. TEALL: Mr. Speaker, gentlemen: I have listened with great interest to all the discussion on this particular resolution, particularly with interest to Dr. Carey's discussion. So far as I can see I agree wholeheartedly with what Dr. Carey had to say and yet I'd like to urge you to pass the proposed amendment on which there seems to be divergent opinion. As far as I can see there is only one question here we need to concern ourselves with in the proposed amendment to the committee report, that is the matter of whether we direct C.P.S. to go out and find experimental groups. That could be further amended by screening, if possible; that may take quite a little screening. It seems to me the discussion revolves around the fact whether a California Insurance Corporation or what you call it, our California Insurance Corporation be directed to sell indemnity insurance with the same effort as used in the sale of service contracts. I'd be very eager to hear any discussion at this point as to whether any objections on anybody's part in the House to this position. Unless there be valid objection to this particular position it seems to me no particular harm and a great deal of good can come from the support of the amendment of the Reference Committee.

SPEAKER CHARNOCK: Dr. Teall, do you wish an amendment?

DR. TEALL: I offer an amendment to the amendment in the paragraph which reads, "selection of subscriber groups be started," simply to add the words that it recommends that the selected subscriber groups be started where possible within the year.

SPEAKER CHARNOCK: Any discussion of the amendment to the amendment?

DR. GIBBONS (San Francisco): I would like to discuss the general question. As secretary of the Medical Services Commission I rather welcome the resolution that has been put in and is now under discussion. I wish more of the resolutions of the commission would urge that the various medical

societies be further informed of the California Physicians' Indemnity Service and I think anything that can be said or done to stimulate further action along this type of insurance is welcome to us.

In regard to Dr. Teall's substitute amendment, if that means that it would simply not make it mandatory on us to proceed immediately, allow us a little time to study, I think I would be willing to accept that.

SPEAKER CHARNOCK: If Dr. Thompson will accept that change we won't need to vote on Dr. Teall's amendment. Do you accept that, Dr. Thompson?

DR. THOMPSON: Yes, I will accept that.

SPEAKER CHARNOCK: That is squared away. We are now discussing the amendment as it has been offered.

DR. HODGES: For the benefit of clarification and not persuading one way or the other on any of this, and this discussion applies to all of these, let me tell you something about the background of the two companies. First of all, California Physicians' Service was set up by an enabling act and operates under the Attorney General of the State of California. We are not an insurance corporation.

Secondly, California Physicians' Insurance Corporation which was set up at the direction of the House of Delegates is an insurance corporation and acts directly under the Insurance Commissioner of the State of California. They are two different corporations, one being to sell indemnity insurance, the other being to sell service contracts. That is why the same company cannot with as great vigor sell one as the other. We are directed and bound by those two agencies, the Attorney General on the one hand and the State Insurance Commission on the other. One corporation is to sell one sort and is ready to sell it and is happy to sell it, and the other applies on the other hand—and you may remember of course that your House of Delegates meeting said that these contracts were to be sold and the indemnity contracts were to be offered in counties requesting it. We would feel we would be acting outside our jurisdiction if we went into a county offering the type of plan that had not been requested by that county. I think that background is essential if you are to act upon these resolutions.

DR. CAREY: In my remarks a moment ago I was referring particularly—and I don't think I made it plain—to the fact when Dr. Thompson read this he read the specification in it of one year, he said that that must be done within one year. In the printed type that I have in my hand at the time this was not in there. I am not objecting particularly to this, therefore, since the typed copy since handed out does not contain that stipulation.

DR. BOEHME (Los Angeles): A point of information, please, Mr. Speaker. I have lost my copy and I think others have, too. The discussion is varied. You make an amendment to the amendment, and in the resolution we have to have a pilot plan of indemnity, we couldn't sell indemnity and deductible insurance, or is this to be indemnity insurance *per se*?

SPEAKER CHARNOCK: My understanding of this amendment, and there is only one because this proposed amendment has been accepted with the small change by Dr. Teall—that they get out and sell some indemnity insurance. Does Dr. Thompson have anything more to say about that? You wanted to speak?

DR. THOMPSON: I didn't see the copy that was given to Dr. Carey, but in the copy that I gave to the chairman in which "within this year" is included, there might have been a typographical error on some of these copies, and that this selected experimental subscriber group be started within the year was in the original.

SPEAKER CHARNOCK: That is in the amendment we have here and is changed. It is recommended experimental subscriber groups be started within the year as a practical aid to this study, "and that it be further *Resolved*, That the county requesting indemnity insurance which has been approved by the California Insurance Commission, California Insurance Corporation, be directed to sell indemnity insurance with the same effort it is using in the sale of service contracts." That is the amendment that has been submitted. Is there any amendment to the amendment?

MEMBER FROM THE FLOOR: A point of information. I ask the question of Dr. Kilroy on the wording, have you not eliminated the principle of coinsurance and deductible?

DR. KILROY: I will answer it. No, you have not. Under the previous action by this House whereby a county may request that indemnity insurance be sold within that county they also retain the right to specify that they wish included in that any additional features such as dollar deductibility or coinsurance.

SPEAKER CHARNOCK: Thank you. Dr. Reynolds, of Alameda-Contra Costa County.

DR. T. ERIC REYNOLDS (Alameda-Contra Costa County): I think it might facilitate our action on this if one or two points were clarified. I am sure it is the general thinking of the California Physicians' Service Trustees, as well as the Medical Services Commission, that their implementations of indemnity insurance are being furnished wherever there is a legitimate request for that implementation.

I think many of us might agree also that we would be quite happy if that could be done within a month, or whatever time it might take to find that proper experimental group and start working on it. It seems that there is some confusion in the minds of several people as to whether or not the proponents, including Dr. Thompson, wish the stipulation of one year included; if he does I would like to suggest an amendment to Dr. Thompson's amendment and that the period of one year be deleted and that "all possible haste" which is at the

same time consistent with good economic policy be substituted for the stipulated period of one year, that is, if you have not changed it.

DR. THOMPSON: I have not changed it.

SPEAKER CHARNOCK: If Dr. Thompson will accept that change, eliminating "within the year," we will not have to put another amendment on it; otherwise it is amended to change that. Dr. Thompson, do you accept that, do you want it changed?

DR. THOMPSON: I think we ought to vote on it.

SPEAKER CHARNOCK: Is that amendment to the amendment seconded?

... The amendment to the amendment was seconded.

SPEAKER CHARNOCK: Those in favor of the amendment presented by Dr. Reynolds, striking out the term "within the year," will signify by saying aye. The ayes have it, the amendment of Dr. Reynolds, eliminating "within the year" has been passed.

You will now vote upon the amendment as amended. Is there any further discussion on the amendment as amended?

DR. A. B. SIRBU (San Francisco): I rise to a point of clarification. It seems to me before we can vote on this intelligently we should know just how it could be implemented. As I understand the intent of this amendment the purpose was to respond to those counties who requested, "and to with equal vigor sell, attempt to sell that type of insurance, on the presentation of the present Board of Trustees as elected." Apparently we have two separate organizations, I'd like to know, do we have two separate boards of trustees, do we have two separate sales forces? Who is going to implement this anyway? If we don't have an equal organization from the indemnity portion of the California Physicians' Service, the whole debate is academic.

DR. HODGES: You are required by law to have two separate organizations. California Physicians' Service does not sell insurance; so we must have two separate organizations. We do not even have the same directorate. In some cases members of the Board of Directors of C.P.S. are on the Board of Directors of the California Physicians' Insurance Corporation. The two must be separate according to the State of California. If you request further clarification on that I suggest you ask our legal counsel, who can point out this with respect to the fact they must be different. There are separate organizations assigned to the selling of these two; they cannot be the same.

SPEAKER CHARNOCK: Dr. Hodges, can you tell us if there are a proportional number of salesmen selling one and the other? I think that is the meat of the question, if a sufficient sales force is selling indemnity insurance.

DR. HODGES: You have the same force to sell indemnity insurance under the demand at present in the State of California. If all the counties of the State of California should request indemnity insurance there would be a sales force set up for that purpose. As it is there is not and there could not be, it would not be economical.

SPEAKER CHARNOCK: I think that answers the question. Mr. Hassard, do you have anything further to add?

MR. HASSARD: Not unless the House wishes.

SPEAKER CHARNOCK: If the House wishes any further clarification by legal counsel? We will now vote. Those in favor of the amendment as amended will signify by saying aye.

... The motion was carried.

SPEAKER CHARNOCK: Are you ready to vote upon Resolution No. 6, substitute resolution, as amended? Those who are in favor of Resolution No. 6, a substitute resolution proposed, as amended, will signify by saying aye.

... The motion was carried.

DR. KILROY: Resolution No. 7, introduced by Herbert Moffitt, Jr., San Francisco Medical Society.

Resolved, That C.P.S. be directed to develop these economic and geographical spheres and to develop the premium schedules with accompanying fees which together will be commensurate with these great differences in subscriber income and the cost of providing the best medical care."

Because this is a subject of continuing study by the subcommittee on principles of fee schedules of the Medical Services Commission your committee sees no necessity for this resolution and therefore we recommend it *do not pass.*

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded.

SPEAKER CHARNOCK: The adoption of this section of the report has been moved and seconded. Any discussion?

DR. CLAUDE P. CALLAWAY (San Francisco): Mr. Speaker, members of the House: The resolution is simply asking C.P.S. to recognize two facts, one, that there is a great difference in providing hospital services for large numbers of communities all over the state, and the second fact has been brought out about these of the study committee that there is a difference in cost of providing the best medical care varying from one community to another. Actually we know that that is true, but we do not know that there has been any direction to implement a study directed toward developing different fee schedules throughout the state.

Principally I think that the proposition to accept the resolution would take different lines; maybe those are difficulties in administration and decentralizing situations, the difficulties of determining where such boundaries would be and to decide them, and finally that of the mobile population of the state. Actually, these are administrative difficulties, however heavy they may be, and we can concern ourselves as to whether or not C.P.S. is flexible enough

to meet such challenges of facts that we know to exist.

I believe that the funds of C.P.S. are probably capable of such applicability and that we should find out. I think that may be the impression of justice to patients in various communities, certainly it may be a real question to members of, loyal members of C.P.S. in many communities who find it increasingly difficult to practice under present fee schedules. Primarily, though, it may be a question of good will between physicians of various communities and an understanding of problems which occur in communities other than their own. I should like to be directed and know for sure that such studies have been directed by the Council along these lines because to your knowledge although the facts are there we should like to know that there had been specific direction to study and implement the result of certain geographical or economic differences.

DR. KILROY: Only to this extent, that we were informed that this has been a subject of study by this particular subcommittee of the Medical Services Commission. We had no information that they have been directed to implement this and to bring forth any specific report on that particular item. That has been a phase of the many studies that they have carried on.

SPEAKER CHARNOCK: Dr. Carey.

DR. CAREY: Mr. Speaker, members of the House: I am sorry to take up your time. I think we need a little clarification on this. As you know, in brief, C.P.S. has been directed to determine these economic factors, etc. That is not a function of C.P.S. As I explained to you in my report of last Sunday, the Medical Services Commission through its subcommittee has charge of this implementation of changes in fee schedules and through them to the Council and to the C.P.S. Board of Trustees. This was not a logical function of C.P.S., this is a function of C.M.A.

SPEAKER CHARNOCK: Thank you, Dr. Carey. Are you ready to vote upon this resolution?

. . . The motion was put to a vote, and carried.

SPEAKER CHARNOCK: That will throw out or negate this resolution.

DR. KILROY: Resolution No. 8, introduced by Dr. Herbert Moffitt, San Francisco Medical Society.

"*Resolved*, That the C.P.S. be obligated to pay the $4,200 to $6,000 fee schedule on any and all contracts in which the premium is collected on this basis, regardless of the quoting of a composite premium."

Your committee feels that that resolution covers a subject which is an actuarial and administrative problem. The committee feels that the composite rate is perhaps misunderstood by some physician members of C.P.S. and to eliminate this misunderstanding we offer the following explanation.

In cases where the employer pays a substantial portion of the dues of each of his employees, and makes that contribution on a so-many-cents-per-dollar basis, he then requests a single rate for all people covered. This is a composite rate. This may be illustrated as follows: That in a group of one thousand employees, five hundred of whom received less than $4,200 per year and five hundred of whom received between $4,200 and $6,000 per year, the composite rate is figured as follows:

Five hundred at $3 per person and five hundred at $4 per person, the composite rate is then $3.50. The doctor's fees for the first five hundred employees are paid on Schedule A, doctor's fees on second five hundred paid on Schedule B, irrespective of composite rate. Since your committee feels that is the proper medium in such cases where a composite rate is offered and since this committee has been informed by representatives of the Board of Trustees of C.P.S. that that is the practice at the present time, your committee therefore recommends *do not pass.*

Mr. Speaker, I recommend the adoption of this section of the report.

. . . The motion was seconded.

SPEAKER CHARNOCK: It has been moved and seconded. Any discussion? Dr. Moffitt.

DR. MOFFITT: I disagree with some of the examples cited, but as they introduced this resolution, as I say, the mere fact that it has been introduced has led to a better understanding between us and the C.P.S. Trustees, and on that basis we would go along with the recommendation of the committee that it do not pass.

SPEAKER CHARNOCK: Thank you. Any further discussion? Those in favor of this section of the report signify by saying aye.

. . . The motion to accept this section of the report was carried.

DR. KILROY: Your committee wishes to thank the large number of physicians who attended the C.P.S. Reference Committee hearing and to express our appreciation of their interest and the advice given by them to our committee.

Your chairman wishes to thank Shirley Harcourt and the members of this committee for their many hours of service. Respectfully submitted.

Mr. Speaker, I move the adoption of the report as a whole, as amended.

. . . The motion was seconded.

SPEAKER CHARNOCK: The report as a whole, as amended, has been moved and seconded. Any further discussion?

. . . The motion to accept the report as a whole, as amended, was put to a vote, and carried.

SPEAKER CHARNOCK: At this time the chair wishes to thank each of the members of the Reference Committee. Several years ago some of our lady members of this House said we never made any use of our ladies. Now we have them, two of them have become chairmen of reference committees, and a very fine job they have done.

At this time, for just a moment I'd like to present Mrs. Matthew N. Hosmer, president of the Woman's Auxiliary to the California Medical Association, and she is sitting at the back of the House. Mrs. Hosmer, will you stand up?

And likewise Mrs. Stone, chairman of the Legislative Committee of the Woman's Auxiliary. Will Mrs. Stone stand up? Thank you.

There is no unfinished business, I am told by the secretary. Is there any new business?

MEMBER FROM THE FLOOR: I'd like to present an emergency resolution.

SPEAKER CHARNOCK: Dr. Buerger.

DR. WALTER R. BUERGER: This resolution is being presented and has the approval of the doctors of the Mental Health Committee of California Medical Association particularly and is as follows:

"The day before yesterday the City Councilors' Expansion Committee of Long Beach voted to postpone action for sixty days on an ordinance to certify psychologists locally. Since local psychiatrists are not content with the policies used in implementing the C.M.A. legislative program, this resolution is being introduced:

"WHEREAS, All treatment of mental aberrations is in reality the practice of medicine; therefore be it

"*Resolved,* That this legislation concerning it should be handled on a state, not a local level."

SPEAKER CHARNOCK: Under Chapter 5, Section 9, of the By-Laws, the Speaker of the House concurring, "shall refer said reports or resolutions and business to a Reference Committee." Now if you do not concur that we send this to a reference committee I would like a motion not to refer so that we can expedite that and vote on it at the present moment if you so wish.

. . . It was moved and seconded that this be done.

SPEAKER CHARNOCK: It has been moved and seconded that we do not need to refer that to a reference committee. All those in favor will signify by saying aye. It is carried.

Now any discussion upon the resolution? Those who are in favor of this resolution will signify by saying aye.

. . . The motion was carried.

SPEAKER CHARNOCK: The next order of business is the presentation of your officers and I will ask our president to present the new officers. . . . But first, Dr. Regan.

DR. REGAN (Los Angeles): As chairman of the Radio and Television Committee of Los Angeles County Medical Association I'd like to invite all the members of the House of Delegates and members of the C.M.A. to submit suggestions for subjects or stories for the forthcoming programs to be used in Medic. Send your stories or your suggestions to the L.A.C.M.A. TV-Radio Committee, or to Medic Television Productions, Inc. We appreciate your cooperation.

SPEAKER CHARNOCK: Thank you very much. At this time we will ask Dr. Arlo Morrison to present to this House your new officers.

DR. ARLO MORRISON: Mr. Speaker, members of the House: I think you have seen this man around for a good many years, I think you all know what a very fine fellow he is. I think I made my sentiments about this clear, Sidney, so I'd like to reintroduce my old friend Sidney Shipman. (Applause.)

PRESIDENT SHIPMAN: Thank you very much, Dr. Morrison. I am of course very mindful of the honor which you have done me. It has been a great pleasure to have served you this past year. It seems to me it has been a year of real accomplishment on the part of the California Medical Association. I want to thank Dr. Morrison, who has been extremely generous in his advice and his help. I'd like to thank the Council and the full time staff. The staff has done a grand job. It goes without saying that I will do the very best I can this coming year.

DR. MORRISON: And next is a gentleman on my right, whom I have had the pleasure of knowing and working with very closely for many years. You have seen him in action before this body for a total of nine years. I don't think that there is anything that I can add to the high caliber of his past, nor to increase your esteem for him other than to state the high caliber of the manner in which he has handled his office—Don Charnock. (Applause.)

DR. MORRISON: And on my left we have the new Speaker of your House. I happen to know a great deal of the work that Jim has done because in these offices you have to attend to keep in touch with everything that is going on and it is a very difficult job. I think the past presidents will tell you sometimes it is hard to know how both your right and left hand are doing, but I know of Jim's background, the work he has done, and I feel he will do a fine job for us here. Jim Doyle. (Applause)

DR. MORRISON: Last but not least, our new Vice-Speaker, Paul Foster. As you know he is a past president of the Los Angeles County Medical Association. All his qualifications were given this morning. Paul Foster. (Applause.)

SPEAKER CHARNOCK: Thank you, Dr. Morrison. At this time we will ask Dr. Green to perform a little task.

DR. GREEN: Mr. Speaker, members of the House: It is indeed a pleasure for me to do this little job for our President Arlo. I don't think in the history of the Association it has ever occurred before, with one exception, where a fifteen-year man introduced his captain to the ten-year man, and as past president I don't think that has occurred before. Another unique thing happens, I am a lieutenant in the United States Medical Reserve, of course, or was, and I am now up right in the middle between my own captains. It is usually the other way about, the captain distributes the honors, but I have the honor to do it this time for a senior officer.

It seems also something worth mentioning that on this little plaque which we will give to him in recognition of his valuable service to us which was done willingly, done with every bit of dynamite in him; nothing was left out as far as he was concerned that he could do, but this should be inscribed, "To Arlo A. Morrison, M.D., and Mrs. Morrison." Arlo, we give you this as a token of our appreciation and it has absolutely no intrinsic value.

DR. MORRISON: It is true that the reward is not very valuable perhaps, but the thought behind it is something that money could not purchase. As I have said before, it is a great pleasure as a small town boy to serve you. It is a terrific honor for us out in the country to be recognized once in a while and we like to try to reciprocate by doing a somewhat worthwhile job.

This is something I can put on my wall and I will treasure it over the years, but there was something else that you did this morning that makes me feel also that these two years are worth while. I have served for three years on the Board of California Physicians' Service and I think most of you remember that not too long ago that was a certain kiss of death. I fully expected to see competition from the floor and was quite surprised when it didn't come. To me that is a very great compliment for these past two years of service, but one thing since I am on the Board of Trustees, I think I would like to say. That is to refer you to my remarks of this House of Delegates, how I feel about indemnity insurance, and whether or not they should be purchased. I think they should be.

SPEAKER CHARNOCK: Thank you, Dr. Morrison. At this time we will require a motion to approve the minutes that the committee will edit. It takes approval of the motion that they be edited.

... A motion to approve the minutes that the committee will edit was made and seconded.

... The motion was put to a vote, and carried.

SPEAKER CHARNOCK: Dr. Lum.

DR. LUM: Mr. Speaker, I'd like to make a few announcements. I have been asked to announce that C.P.S. Trustees will meet for organization purposes in Room 7002 immediately after adjournment.

Fifteen minutes later the Council will meet in the California Room. The Council will prepare a tape recording of the poliomyelitis vaccine situation. All those of you who are interested may obtain this statement in Room A, the C.M.A. Room, in about an hour and a half. A copy of this statement will be sent to every town and county medical society.

SPEAKER CHARNOCK: Thank you, Dr. Lum. Any further business to come before this House?

One cannot relinquish the gavel of this House, after nine years of service, without a feeling of nostalgia. My thoughts go first to Dr. Lewis A. Alesen, under whom I served for six years. He is a great example to follow, and a wonderful teacher. My thanks go also to Henry Randel and Wilbur Bailey, who eased the load while they were vice-speakers. You have been a grand group of folks to work for. It has been a privilege to serve you.

If there is no further business, we stand adjourned.

... The meeting was adjourned at 4:30 p.m.